

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02738

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>	c. LENGTH OF STAY IN 1b <u>4 yrs. 1 mo. 10 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Emmitsburg</u> <u>10 X 2 2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>P.O. Box 267</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Harriett</u> Middle <u>White</u> Last <u>ANNAN</u>		4. DATE OF DEATH Month <u>March</u> Day <u>24</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 23, 1865</u>
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Unknown</u> <u>William R. Annan</u> <u>White</u>	
14. MOTHER'S MAIDEN NAME <u>- Unknown</u> <u>Annie Horner</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>219-20-0902</u>		17. INFORMANT <u>Springfield Hospital records.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.B.S. assoc. with changes of growth, metabolism, or nutrition, senile brain disease with psychotic reaction.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>
21. I certify that I attended the deceased from <u>February 14, 1953</u> , to <u>March 24, 1957</u> , that I last saw the deceased alive on <u>March 24, 1957</u> , and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walther H. Sonnenfeldt</u>		ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u>	
PHYSICIAN'S NAME (Type) <u>Walther H. Sonnenfeldt, M.D.</u>		DATE SIGNED <u>3/25/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/27/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Emmitsburg, Pa</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>S. L. Allison</u>		24. REGISTRAR'S SIGNATURE <u>C. Harry Hays</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
MAYNARD		MAY 1957	
AGE		SEX	
DATE OF BIRTH		PLACE OF BIRTH	
MARRIAGE		OCCUPATION	
EDUCATION		RELIGION	
MANNER OF DEATH		CAUSE OF DEATH	
IMMEDIATE CAUSE		MEDICAL HISTORY	
PRE-EXISTING DISEASES		TREATMENT	
POST-MORTEM EXAMINATION		LABORATORY TESTS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE		PLACE	

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CERTIFICATE OF DEATH

Reg. Dist. No.

26

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Patapsco</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Patapsco</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Patapsco Rd</u>				d. STREET ADDRESS <u>Patapsco Rd</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Beulah</u> <u>Jessie</u> <u>ARB496</u>				4. DATE OF DEATH Month Day Year <u>March</u> <u>2</u> <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 16, 1896</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George Wesley Pickett</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Elizabeth Leppo</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>George William Pickett - Patapsco Md.</u> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma Lung</u> <u>170x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> DUE TO (c) <u>Left Breast Aug 1953</u> INTERVAL BETWEEN ONSET AND DEATH <u>July 1956</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 4th</u> , 19 <u>56</u> to <u>March 3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>February 27</u> , 19 <u>57</u> , and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.				ADDRESS (Street, city or town, state) <u>Hampstead Md</u> DATE SIGNED <u>3/3/57</u>			
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>				<u>HAMPSTEAD Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-5-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Carrollton Church of God</u>		22d. LOCATION (City, town, or county) (State) <u>Carrollton, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John R. Byers</u> ADDRESS <u>Westminster, Md.</u>				24a. REC'D BY REGISTRAR <u>3-4-57</u>		24b. REGISTRAR'S SIGNATURE <u>Harriet Imle</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Balto. City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>21</u> days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>AUER</u> Last <u>AUER</u>				4. DATE OF DEATH Month <u>March</u> Day <u>29</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1872</u> <u>Aug. 21, 1870</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>16</u> Hours <u>00</u> Min. <u>00</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sexton Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Unk</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George Auer</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth -</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>218-12-3343</u>		17. INFORMANT <u>Springfield Hospital Records.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>C.B.S. associated with arteriosclerosis with psychotic reaction.</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>March 27, 1957</u> , to <u>March 29, 1957</u> , that I last saw the deceased alive on <u>March 28, 1957</u> , and that death occurred at <u>7:00A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edmund B. Lusthaus</u> M.D.				ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> DATE SIGNED <u>3/29/57</u>			
PHYSICIAN'S NAME (Type) <u>Edmund B. Lusthaus, M.D.</u>				<u>Sykesville, Maryland.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/1/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>A.A. Co. Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>				ADDRESS <u>5305 Harford Road #14</u>		24a. REC'D BY REGISTRAR <u>3-29-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>C. Henry New</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02741

02735

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Sykesville, Maryland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick, Maryland</u>			
c. LENGTH OF STAY IN 1b <u>6 days</u>				d. STREET ADDRESS <u>480 W. South Street</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mary Catherine Elizabeth Poole Barthlow</u> (Also known as <u>Mary E. Barthlow</u>)				4. DATE OF DEATH Month <u>3</u> Day <u>18</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>7-5-1915</u>	
9. AGE (In years last birthday) <u>41</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Presser</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clothing Firm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ernest Poole</u>				14. MOTHER'S MAIDEN NAME <u>Goldie Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unk</u>		17. INFORMANT Address <u>Hospital records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rheumatic heart disease, active</u> <u>401.3</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Psychotic depressive reaction</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-12</u> , 19 <u>57</u> , to <u>3-18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-18</u> , 19 <u>57</u> , and that death occurred at <u>4:25</u> A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edmund Lusthaus</u>				ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u>		DATE SIGNED <u>3-18-1957</u>	
PHYSICIAN'S NAME (Type) <u>Edmund Lusthaus, M.D.</u>				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>21 March 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison & Son, Frederick, Maryland</u>				24a. REC'D BY REGISTRAR <u>9-20-57</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Wain</u>	

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BUREAU V. 2

MAYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10		MAYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10	
CERTIFICATE OF DEATH		CERTIFICATE OF DEATH	
1. NAME OF DECEASED		1. NAME OF DECEASED	
2. SEX		2. SEX	
3. AGE		3. AGE	
4. DATE OF BIRTH		4. DATE OF BIRTH	
5. PLACE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		6. OCCUPATION	
7. CAUSE OF DEATH		7. CAUSE OF DEATH	
8. PLACE OF DEATH		8. PLACE OF DEATH	
9. DATE OF DEATH		9. DATE OF DEATH	
10. SIGNATURE OF DECEASED		10. SIGNATURE OF DECEASED	
11. SIGNATURE OF WITNESS		11. SIGNATURE OF WITNESS	
12. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF CORONER		13. SIGNATURE OF CORONER	
14. SIGNATURE OF JURY		14. SIGNATURE OF JURY	
15. SIGNATURE OF JUDGE		15. SIGNATURE OF JUDGE	
16. SIGNATURE OF CLERK		16. SIGNATURE OF CLERK	
17. SIGNATURE OF NOTARY		17. SIGNATURE OF NOTARY	
18. SIGNATURE OF SHERIFF		18. SIGNATURE OF SHERIFF	
19. SIGNATURE OF DEPUTY SHERIFF		19. SIGNATURE OF DEPUTY SHERIFF	
20. SIGNATURE OF JAILER		20. SIGNATURE OF JAILER	
21. SIGNATURE OF WARDEN		21. SIGNATURE OF WARDEN	
22. SIGNATURE OF CHIEF OF POLICE		22. SIGNATURE OF CHIEF OF POLICE	
23. SIGNATURE OF DEPUTY CHIEF OF POLICE		23. SIGNATURE OF DEPUTY CHIEF OF POLICE	
24. SIGNATURE OF SHERIFF		24. SIGNATURE OF SHERIFF	
25. SIGNATURE OF DEPUTY SHERIFF		25. SIGNATURE OF DEPUTY SHERIFF	
26. SIGNATURE OF JAILER		26. SIGNATURE OF JAILER	
27. SIGNATURE OF WARDEN		27. SIGNATURE OF WARDEN	
28. SIGNATURE OF CHIEF OF POLICE		28. SIGNATURE OF CHIEF OF POLICE	
29. SIGNATURE OF DEPUTY CHIEF OF POLICE		29. SIGNATURE OF DEPUTY CHIEF OF POLICE	
30. SIGNATURE OF SHERIFF		30. SIGNATURE OF SHERIFF	
31. SIGNATURE OF DEPUTY SHERIFF		31. SIGNATURE OF DEPUTY SHERIFF	
32. SIGNATURE OF JAILER		32. SIGNATURE OF JAILER	
33. SIGNATURE OF WARDEN		33. SIGNATURE OF WARDEN	
34. SIGNATURE OF CHIEF OF POLICE		34. SIGNATURE OF CHIEF OF POLICE	
35. SIGNATURE OF DEPUTY CHIEF OF POLICE		35. SIGNATURE OF DEPUTY CHIEF OF POLICE	
36. SIGNATURE OF SHERIFF		36. SIGNATURE OF SHERIFF	
37. SIGNATURE OF DEPUTY SHERIFF		37. SIGNATURE OF DEPUTY SHERIFF	
38. SIGNATURE OF JAILER		38. SIGNATURE OF JAILER	
39. SIGNATURE OF WARDEN		39. SIGNATURE OF WARDEN	
40. SIGNATURE OF CHIEF OF POLICE		40. SIGNATURE OF CHIEF OF POLICE	
41. SIGNATURE OF DEPUTY CHIEF OF POLICE		41. SIGNATURE OF DEPUTY CHIEF OF POLICE	
42. SIGNATURE OF SHERIFF		42. SIGNATURE OF SHERIFF	
43. SIGNATURE OF DEPUTY SHERIFF		43. SIGNATURE OF DEPUTY SHERIFF	
44. SIGNATURE OF JAILER		44. SIGNATURE OF JAILER	
45. SIGNATURE OF WARDEN		45. SIGNATURE OF WARDEN	
46. SIGNATURE OF CHIEF OF POLICE		46. SIGNATURE OF CHIEF OF POLICE	
47. SIGNATURE OF DEPUTY CHIEF OF POLICE		47. SIGNATURE OF DEPUTY CHIEF OF POLICE	
48. SIGNATURE OF SHERIFF		48. SIGNATURE OF SHERIFF	
49. SIGNATURE OF DEPUTY SHERIFF		49. SIGNATURE OF DEPUTY SHERIFF	
50. SIGNATURE OF JAILER		50. SIGNATURE OF JAILER	
51. SIGNATURE OF WARDEN		51. SIGNATURE OF WARDEN	
52. SIGNATURE OF CHIEF OF POLICE		52. SIGNATURE OF CHIEF OF POLICE	
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56. SIGNATURE OF JAILER		56. SIGNATURE OF JAILER	
57. SIGNATURE OF WARDEN		57. SIGNATURE OF WARDEN	
58. SIGNATURE OF CHIEF OF POLICE		58. SIGNATURE OF CHIEF OF POLICE	
59. SIGNATURE OF DEPUTY CHIEF OF POLICE		59. SIGNATURE OF DEPUTY CHIEF OF POLICE	
60. SIGNATURE OF SHERIFF		60. SIGNATURE OF SHERIFF	
61. SIGNATURE OF DEPUTY SHERIFF		61. SIGNATURE OF DEPUTY SHERIFF	
62. SIGNATURE OF JAILER		62. SIGNATURE OF JAILER	
63. SIGNATURE OF WARDEN		63. SIGNATURE OF WARDEN	
64. SIGNATURE OF CHIEF OF POLICE		64. SIGNATURE OF CHIEF OF POLICE	
65. SIGNATURE OF DEPUTY CHIEF OF POLICE		65. SIGNATURE OF DEPUTY CHIEF OF POLICE	
66. SIGNATURE OF SHERIFF		66. SIGNATURE OF SHERIFF	
67. SIGNATURE OF DEPUTY SHERIFF		67. SIGNATURE OF DEPUTY SHERIFF	
68. SIGNATURE OF JAILER		68. SIGNATURE OF JAILER	
69. SIGNATURE OF WARDEN		69. SIGNATURE OF WARDEN	
70. SIGNATURE OF CHIEF OF POLICE		70. SIGNATURE OF CHIEF OF POLICE	
71. SIGNATURE OF DEPUTY CHIEF OF POLICE		71. SIGNATURE OF DEPUTY CHIEF OF POLICE	
72. SIGNATURE OF SHERIFF		72. SIGNATURE OF SHERIFF	
73. SIGNATURE OF DEPUTY SHERIFF		73. SIGNATURE OF DEPUTY SHERIFF	
74. SIGNATURE OF JAILER		74. SIGNATURE OF JAILER	
75. SIGNATURE OF WARDEN		75. SIGNATURE OF WARDEN	
76. SIGNATURE OF CHIEF OF POLICE		76. SIGNATURE OF CHIEF OF POLICE	
77. SIGNATURE OF DEPUTY CHIEF OF POLICE		77. SIGNATURE OF DEPUTY CHIEF OF POLICE	
78. SIGNATURE OF SHERIFF		78. SIGNATURE OF SHERIFF	
79. SIGNATURE OF DEPUTY SHERIFF		79. SIGNATURE OF DEPUTY SHERIFF	
80. SIGNATURE OF JAILER		80. SIGNATURE OF JAILER	
81. SIGNATURE OF WARDEN		81. SIGNATURE OF WARDEN	
82. SIGNATURE OF CHIEF OF POLICE		82. SIGNATURE OF CHIEF OF POLICE	
83. SIGNATURE OF DEPUTY CHIEF OF POLICE		83. SIGNATURE OF DEPUTY CHIEF OF POLICE	
84. SIGNATURE OF SHERIFF		84. SIGNATURE OF SHERIFF	
85. SIGNATURE OF DEPUTY SHERIFF		85. SIGNATURE OF DEPUTY SHERIFF	
86. SIGNATURE OF JAILER		86. SIGNATURE OF JAILER	
87. SIGNATURE OF WARDEN		87. SIGNATURE OF WARDEN	
88. SIGNATURE OF CHIEF OF POLICE		88. SIGNATURE OF CHIEF OF POLICE	
89. SIGNATURE OF DEPUTY CHIEF OF POLICE		89. SIGNATURE OF DEPUTY CHIEF OF POLICE	
90. SIGNATURE OF SHERIFF		90. SIGNATURE OF SHERIFF	
91. SIGNATURE OF DEPUTY SHERIFF		91. SIGNATURE OF DEPUTY SHERIFF	
92. SIGNATURE OF JAILER		92. SIGNATURE OF JAILER	
93. SIGNATURE OF WARDEN		93. SIGNATURE OF WARDEN	
94. SIGNATURE OF CHIEF OF POLICE		94. SIGNATURE OF CHIEF OF POLICE	
95. SIGNATURE OF DEPUTY CHIEF OF POLICE		95. SIGNATURE OF DEPUTY CHIEF OF POLICE	
96. SIGNATURE OF SHERIFF		96. SIGNATURE OF SHERIFF	
97. SIGNATURE OF DEPUTY SHERIFF		97. SIGNATURE OF DEPUTY SHERIFF	
98. SIGNATURE OF JAILER		98. SIGNATURE OF JAILER	
99. SIGNATURE OF WARDEN		99. SIGNATURE OF WARDEN	
100. SIGNATURE OF CHIEF OF POLICE		100. SIGNATURE OF CHIEF OF POLICE	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 FilmG212 3-22-57 et

CERTIFICATE OF DEATH

02736

02742

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb since 2-15-57	
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Phillip Middle Bernard Last Bernard		4. DATE OF DEATH Month 3 Day 9 Year 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-9-74
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 8 Days 2 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) actor		10b. KIND OF BUSINESS OR INDUSTRY So. Carolina	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Phillip Bernard		14. MOTHER'S MAIDEN NAME Mary Baker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unkn		16. SOCIAL SECURITY NO. 320-05-3108	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis with psych. reaction			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-15- , 19 57 , to 3-9-57 , that I last saw the deceased alive on March 9, 19 57 , and that death occurred at 6 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 3-10-57 ACTUAL SIGNATURE Edmund Luthans M.D. PHYSICIAN'S NAME (Type) Sykesville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Mar. 13/57		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Cathedral		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Rita Wiedefeld		24. REC'D BY REGISTRAR Mar 13 1957	
ADDRESS Biddle St.		24b. REGISTRAR'S SIGNATURE C. Harry Myers	

15

1

1

AP

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH	
JAMES EARL RAY		M		35		W		12-1-28		MEMPHIS, TENN.		4-4-68		MEMPHIS, TENN.	
9. OCCUPATION		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. MEDICAL HISTORY		13. PRESENT ILLNESS		14. TREATMENT		15. POST-MORTEM		16. SIGNATURE OF PHYSICIAN	
ATTORNEY		SHOOTING		HOMICIDE		NONE		SHOOTING		NONE		NONE		JAMES EARL RAY	
17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESS		19. SIGNATURE OF WITNESS		20. SIGNATURE OF WITNESS		21. SIGNATURE OF WITNESS		22. SIGNATURE OF WITNESS		23. SIGNATURE OF WITNESS		24. SIGNATURE OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

BUREAU V. S.

MAR 13 1967

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02737

CERTIFICATE OF DEATH

02743

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FINKSBURG		c. LENGTH OF STAY IN 1b 20 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FINKSBURG x2 RD#1	
		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First HOWARD Middle EDWARD Last BONNER		4. DATE OF DEATH Month MARCH Day 8 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 8, 1909
9. AGE (In years lost, birthday) 47 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ACCOUNTANT		10b. KIND OF BUSINESS OR INDUSTRY CONGREGATION - NAIRN	
11. BIRTHPLACE (State or foreign country) MD. U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME HENRY EDWARD BONNER		14. MOTHER'S MAIDEN NAME AMELIA MILLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS. H. F. BONNER, FINKSBURG, MD. RD#1		Address	
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain Tumor (Malignant) 193X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 56 to 3-8-57 , that I last saw the deceased alive on 3-7-57 , and that death occurred at 12:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE M. C. Porterfield M.D.		ADDRESS (Street, city or town, state) Hampstead, Md. DATE SIGNED 3/8/57	
PHYSICIAN'S NAME (Type) M. C. Porterfield M.D.		Hampstead, Md. 3/8/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/10/57	
22c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		22d. LOCATION (City, town, or county) (State) CARROLL CO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE J. S. Myers, Jr. Westminster, Md.		24a. REC'D BY REGISTRAR DATE 3-8-57	
		24b. REGISTRAR'S SIGNATURE Harold Miller	

CERTIFICATE OF DEATH

1. Name of Deceased: *JOHN EDWARD SMITH*

2. Date of Death: *MAR 10 1957*

3. Place of Death: *HOME*

4. Age: *45*

5. Sex: *M*

6. Race: *W*

7. Marital Status: *M*

8. Occupation: *CLERK*

9. Cause of Death: *HEART DISEASE*

10. Physician: *DR. J. H. SMITH*

11. Burial Place: *ST. MARY'S CATHEDRAL*

12. Date of Burial: *MAR 12 1957*

13. Signature of Physician: *[Signature]*

14. Signature of Registrar: *[Signature]*

BUREAU Y. B.

MAR 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02744

02738

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>City</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>Since 1-20-55</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>1101 Binney Street</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Baker</u> Last <u>BORKOWICZ</u>		4. DATE OF DEATH Month <u>March</u> Day <u>5</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-5-86</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Toolroom Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Borkowicz</u>		14. MOTHER'S MAIDEN NAME <u>Constance Antkowiak</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-07-4235</u>	
17. INFORMANT <u>Records - Springfield State Hospital</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia - Hypostatic</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome associated with circulatory disturbance with cerebral arteriosclerosis with psychotic reaction.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>January 20</u> , 19 <u>55</u> , to <u>3-5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>March 5</u> , 19 <u>57</u> , and that death occurred at <u>11 A.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walther H. Sonnenfeldt</u>		ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>3/5/57</u>	
PHYSICIAN'S NAME (Type) <u>Walther H. Sonnenfeldt, M. D.</u>		<u>Sykesville, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-9-57</u>	22c. NAME OF CEMETERY OR CREMATOR <u>ST. STANISLAUS</u>	22d. LOCATION (City, town, or county) (State) <u>1300 DUNDALK AVE</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>George A. Weber</u>		ADDRESS <u>705 S. Penn st</u>	
24a. REC'D BY REGISTRAR <u>3/6/57</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Kern</u>	

RECEIVED

MAR 7 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02745

02739

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>				c. LENGTH OF STAY IN 1b <u>YEARS</u> <u>X2</u> <u>UNION BRIDGE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RURAL</u>				d. STREET ADDRESS <u>1 RURAL</u>			
3. NAME OF DECEASED (Type or print) <u>LAURA PRICE BOSTIAN</u>				4. DATE OF DEATH <u>MARCH 12 1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 24-1875</u>	9. AGE (In years last birthday) <u>81</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>							
13. FATHER'S NAME <u>JACOB PRICE</u>				14. MOTHER'S MAIDEN NAME <u>ALICE KELLY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>GC. BOSTIAN</u>				Address <u>UNION BRIDGE P.D. MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>331X</u> <u>Cerebral Hemorrhage</u> DUE TO <u>Arterial Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Mar 12, 1957</u> to <u>Mar 12, 1957</u> , that I last saw the deceased alive on <u>Mar 10, 1957</u> , and that death occurred at <u>2:25 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. H. MESSLER</u> M.D.				ADDRESS (Street, city or town, state) <u>Union Bridge Md.</u>			
DATE SIGNED <u>Mar 12 1957</u>							
PHYSICIAN'S NAME (Type) <u>J. H. MESSLER M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/14/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LUTHERAN CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>UNIONTOWN, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. H. Harkley</u>				ADDRESS <u>Union Bridge, Md.</u>			
24a. REC'D BY REGISTRAR <u>Reid</u>				24b. REGISTRAR'S SIGNATURE <u>Reid</u>			
DATE <u>3-14-57</u>							

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		65		M		W		1892		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES	
STREET ADDRESS		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
1234 E. BALTIMORE		BALTIMORE		MD		USA		1957		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY OF EXAMINATION		STATE OF EXAMINATION		COUNTRY OF EXAMINATION	
RETIRED		HEART DISEASE		NATURAL		10 DAYS		1957		BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

BUREAU V. S.

MAR 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02740

CERTIFICATE OF DEATH

02746

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>3mo. 11. days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>Cumberland 01-02-2</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Ralph</u> Middle <u>Drew</u> Last <u>BROADRUP</u>				4. DATE OF DEATH Month <u>March</u> Day <u>17</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-13-91</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Banker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Banking</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George L. Broadrup</u>				14. MOTHER'S MAIDEN NAME <u>Emma Wachter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT <u>Springfield State Hospital - Sykesville, Md.</u>			
				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Edema of Lungs</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 hours</u> <u>5 hours</u> <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Huntington's Chorea, with psychotic reaction.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-6</u> , 19 <u>56</u> , to <u>3-17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-17</u> , 19 <u>57</u> , and that death occurred at <u>9:07 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Martin Gross</u>				ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u>		DATE SIGNED <u>3-18-57</u>	
PHYSICIAN'S NAME (Type) <u>Martin Gross, M. D.</u>				<u>Sykesville, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-20-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. Lee Wilcox</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>3-18-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>C. Henry Allen</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
MARRIAGE		MARRIED		SINGLE		WIDOW		DIVORCED		SEPARATED		OTHER	
CAUSE OF DEATH		DISEASE		SYMPTOMS		TREATMENT		HISTORY		PREVIOUS ILLNESS		OTHER	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		HOSPITAL		OTHER	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		SIGNATURE OF JUDGE		SIGNATURE OF OTHER	
DATE OF SIGNATURE		TIME OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE		COUNTRY OF SIGNATURE		HOSPITAL		OTHER	

BUREAU V. S.

MAR 19 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02741

CERTIFICATE OF DEATH

02747
74

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 5yrs. 2mo. 11 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun				✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital.				d. STREET ADDRESS Unknown			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Emma Middle Stephens Last Brown				4. DATE OF DEATH Month March Day 30 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-22-1890	
9. AGE (In years last birthday) yrs. 66		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown				10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Clifford N Brown				14. MOTHER'S MAIDEN NAME Mary Stephens			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. none		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease. 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) Bronchopneumonia				INTERVAL BETWEEN ONSET AND DEATH years years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with convulsive disorder, epileptic deterioration.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Bronchopneumonia			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Springfield State Hospital	
20f. (City or town) Springfield				20g. (County) Carroll		20h. (State) Md	
21. I certify that I attended the deceased from 1-19-51 , 19 51 , to 3-30- 19 57 , that I last saw the deceased alive on 3-30-57 , 19 57 , and that death occurred at 7 P.M. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE: Agustin del Campo				ADDRESS (Street, city or town, state) Springfield State Hospital			
DATE SIGNED 3-31-57							
PHYSICIAN'S NAME (Type) Agustin del Campo. M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-1-1957		22c. NAME OF CEMETERY OR CREMATORY North East Md		22d. LOCATION (City, town, or county) (State) Calverton, Cecil Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R Grant				24a. REC'D BY REGISTRAR APR 2 1957			
ADDRESS North East Md				24b. REGISTRAR'S SIGNATURE C. Harry Heers			

BUREAU V. S.

APR 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02742

CERTIFICATE OF DEATH

Reg. Dist. No.

02748

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 2yrs. 2mos. 6days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Thomas Middle Kent Last BROWN				4. DATE OF DEATH Month March Day 5 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 9, 1874	
9. AGE (In years day birthday) yrs. 82		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stonecutter				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Enoch Brown				14. MOTHER'S MAIDEN NAME Martha Bell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. -		17. INFORMANT Address Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, unresolved DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Gastro-intestinal hemorrhage DUE TO (c) Peptic ulcer PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with circ. disturbance with cerebral arteriosclerosis with psychotic reaction.							
INTERVAL BETWEEN ONSET AND DEATH 24 hrs.							
8 days							
Unknown							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from December 29, 1954 , to March 5, 1957 , that I last saw the deceased alive on March 5, 1957 , and that death occurred at 10:45 A. from the causes and on the date stated above.							
ACTUAL SIGNATURE Walther H. Sonnenfelat				ADDRESS (Street, city or town, state) Springfield Hospital		DATE SIGNED 3/5/57	
PHYSICIAN'S NAME (Type) Walther H. Sonnenfelat, M.D. Sykesville, Maryland.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Buried		3-6-57		St. Mary's Cemetery		Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell				ADDRESS Pikesville, Md.		24a. REC'D BY REGISTRAR DATE 3/7/57	
				24b. REGISTRAR'S SIGNATURE C. Harry Heers			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
JAMES EARL RAY		Male		35		White		April 22, 1928		St. Louis, Mo.		April 4, 1968		St. Louis, Mo.		Suicide		Homicide		[Signature]		[Signature]	
13. OCCUPATION		14. EDUCATION		15. MARITAL STATUS		16. RELIGION		17. PREVIOUS ILLNESS		18. PREVIOUS SURGERY		19. PREVIOUS TRAUMA		20. PREVIOUS DRUGS		21. PREVIOUS ALCOHOL		22. PREVIOUS TOBACCO		23. PREVIOUS OTHER		24. PREVIOUS OTHER	
Attorney		High School		Single		Catholic		None		None		None		None		None		None		None		None	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS		31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

MAR 8 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 50

02743

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE _____ b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u>		c. LENGTH OF STAY IN 1b <u>24 hrs -</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FRANKFURT GERMANY 90X-3</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BRETHERN SERVICE CENTER</u>				d. STREET ADDRESS <u>ROEDELHEIMER LANSTR 36</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SYDILLE</u> Middle <u>BRUECK</u> Last <u>BRUECK</u>				4. DATE OF DEATH Month <u>MAR</u> Day <u>18</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC 13 1932</u>		9. AGE (In years last birthday) <u>24</u> yrs.	10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>COLLEGE</u>		11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>GERMANY</u>	
13. FATHER'S NAME <u>WALTER BRUECK</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Brother-in-law Commissioned</u> Address <u>New Windsor</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SUFFOCATION - by hanging -</u> <u>974X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hanged by neck -</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>3-18</u> 19 <u>57</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>New Windsor</u>		20f. (City or town) (County) (State) <u>Carroll Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Marsh</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/23/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MEISSEN</u>		22d. LOCATION (City, town, or county) (State) <u>MEISSEN GERMANY</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. Hartzler & Sons, New Windsor, Md</u>				24a. REC'D BY REGISTRAR <u>21 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Eric Benedict</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: This certificate should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

MAR 21 1957

BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02750

02741

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 15yrs.6mos.5days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing 01x2.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS -			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Bessie Middle BUCKLE Last BUCKLE				4. DATE OF DEATH Month March Day 1 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 14, 1880		9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Othe Waxler				14. MOTHER'S MAIDEN NAME Levina Green			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 410X		17. INFORMANT Address Springfield Hospital Records.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic mitral valvular heart disease 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Aspiration bronchopneumonia with abscess formation Week. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with Cerebral arteriosclerosis.							INTERVAL BETWEEN ONSET AND DEATH Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1950 , to March 1, 1957 , that I last saw the deceased alive on February 28, 1957 , and that death occurred at 4:50 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D.				ADDRESS (Street, city or town, state) Springfield State Hospital		DATE SIGNED 3/1/57	
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.				Sykesville, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-4-57		22c. NAME OF CEMETERY OR CREMATORY Lonaconing		22d. LOCATION (City, town, or county) (State) Lonaconing, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE M. Eichorn-Lonaconing, Md.				ADDRESS Lonaconing, Md.		24a. REC'D BY REGISTRAR DATE 3-1-57	
				24b. REGISTRAR'S SIGNATURE C. Harry Allen			

BUREAU V. S.

MAR 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02751

02723 CERTIFICATE OF DEATH

Reg. Dist. No.

26

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>				c. LENGTH OF STAY IN 1b <u>50 YRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>204 PENNA. AVE.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> <u>27</u>			
				d. STREET ADDRESS <u>204 PENNA. AVE.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>IRENE ELIZABETH CHREST</u>				4. DATE OF DEATH Month Day Year <u>MARCH 7 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 7, 1875</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>CARROLL CO. MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>CHRISTIAN A. GUNTHER</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE GIGGARD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>MISS LILLIAN L. CHREST, 204 PENNA. AVE, WESTMINSTER MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arterial thrombosis</u> <u>421.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Valvular heart disease</u> DUE TO (c) <u>14 yrs</u>				INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 50</u> to <u>Mar 7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Mar 6</u> , 19 <u>57</u> , and that death occurred at <u>3:05 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>15 Kemper Ave. 9/1/57</u>							
ACTUAL SIGNATURE <u>E. Reese Wilkens</u> M.D.				PHYSICIAN'S NAME (Type) <u>E. Reese WILKENS, Westminister Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>3/9/57</u>		<u>LEISTER'S CEMETERY</u>		<u>RURAL, WESTMINSTER MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. E. Myers, Jr. Westminister, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>3-8-57</u>		24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John William Smith</i>		2. SEX <i>Male</i>		3. AGE <i>65</i>	
4. DATE OF DEATH <i>March 10, 1957</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. STREET ADDRESS <i>1234 Main St.</i>		8. CITY <i>Baltimore</i>		9. STATE <i>Md.</i>	
10. COUNTY <i>Harford</i>		11. ZIP CODE <i>21040</i>		12. MANNER OF DEATH <i>Natural</i>	
13. CAUSE OF DEATH <i>Heart Disease</i>		14. ICD-9 CODE <i>410</i>		15. OTHER CAUSE <i>None</i>	
16. SIGNATURE OF PHYSICIAN <i>Dr. J. K. Smith</i>		17. SIGNATURE OF DECEASED <i>John W. Smith</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>	
19. SIGNATURE OF REGISTRAR <i>John Doe</i>		20. SIGNATURE OF CLERK <i>John Doe</i>		21. SIGNATURE OF CHIEF OF BUREAU <i>John Doe</i>	

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BUREAU V. S.

MAR 11 1957

RECEIVED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02745

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VA.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PURCELL WESTMINSTER</u>				c. LENGTH OF STAY IN 1b <u>7 MO.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.D. 5</u>				d. STREET ADDRESS <u>83X-3</u>			
3. NAME OF DECEASED (Type or print) <u>SAMUEL</u> First <u>MILTON</u> Middle <u>CLEGG</u> Last				4. DATE OF DEATH <u>MARCH</u> Month <u>1</u> Day <u>1957</u> Year			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 25, 1870</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET. FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>VA.</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>DANIEL CLEGG</u>				14. MOTHER'S MAIDEN NAME <u>ELLEN THORPE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>ADA V. CLEGG (wife)</u> Address <u>R.D. 5 WESTMINSTER, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial degeneration</u> 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 weeks</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Feb 1, 1957</u> to <u>Mar 1, 1957</u> , that I last saw the deceased alive on <u>Feb 28, 1957</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>151 Coulter Westminister</u> DATE SIGNED <u>3/2/57</u>							
ACTUAL SIGNATURE <u>E. Reese Wilkins</u> M.D.							
PHYSICIAN'S NAME (Type) <u>E. REESE WILKINS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-3-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ZION METHODIST CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>R.D. 6 WESTMINSTER, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David A. Bankard</u> ADDRESS <u>Westminister, Md.</u>				24a. REC'D BY REGISTRAR <u>3-7-57</u>		24b. REGISTRAR'S SIGNATURE <u>Harold Miller</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
02746
CERTIFICATE OF DEATH

02753
74

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Balto. City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>24 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				e. STREET ADDRESS <u>3523 Brehms Lane,</u>			
3. NAME OF DECEASED (Type or print) First <u>Bernard</u> Middle <u>Vincent</u> Last <u>COLLINS</u>				4. DATE OF DEATH Month <u>March</u> Day <u>7</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 28, 1894</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Grain Elevator</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Collins</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Philbin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>World War I</u>				16. SOCIAL SECURITY NO. <u>213-14-4487</u>		17. INFORMANT <u>Springfield Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.B.S. associated with arteriosclerosis.</u></p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH Years _____</p> </div> </div>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>February 13, 1957</u> , to <u>March 7, 1957</u> , that I last saw the deceased alive on <u>March 6, 1957</u> , and that death occurred at <u>1:00A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walther H. Sonnenfeldt</u> M.D.				ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u>		DATE SIGNED <u>3/7/57</u>	
PHYSICIAN'S NAME (Type) <u>Walther H. Sonnenfeldt, M.D.</u> <u>Sykesville, Maryland.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-11-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Edmondson Ave. Balto: Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Ruth, Inc. - 1735 Harford Avenue, Balto: Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 11 1957</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Heers</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02747

CERTIFICATE OF DEATH

02754

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN b. 3yrs.5mos.3days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS 13 N. Jefferson St.							
3. NAME OF DECEASED (Type or print) First Margie Middle Alice Last ALBAUGH				4. DATE OF DEATH Month March Day 6 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 18, 1880	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George W. Albaugh				14. MOTHER'S MAIDEN NAME Sara Jane Valentine			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Springfield Hospital Records.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 002-X DUE TO (c) C.B.S. associated with circ. disturbance, with cerebral arteriosclerosis, with psychotic reaction.							
INTERVAL BETWEEN ONSET AND DEATH unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION, GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from October 3, 1953 , to March 6, 1957 , that I last saw the deceased alive on March 6, 1957 , and that death occurred at 10:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Walther H. Sonnenfeldt				ADDRESS (Street, city or town, state) Springfield State Hospital			
DATE SIGNED 3/7/57							
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.				Sykesville, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Mar. 9, 1957		22c. NAME OF CEMETERY OR CREMATORY Mt. Tabor, Cemetery		22d. LOCATION (City, town, or county) (State) Rocky Ridge Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Bailey				ADDRESS Frederick Md.		24a. REC'D BY REGISTRAR DATE 9 March 1957	
				24b. REGISTRAR'S SIGNATURE C. Harry Hays			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	
JAMES EARL RAY		M		35		W		1922		MEMPHIS, TENN.		APR 4, 1968		MEMPHIS, TENN.		SHOOTING		HOMICIDE		JAMES EARL RAY		JAMES EARL RAY	
13. OCCUPATION		14. EDUCATION		15. RELIGION		16. MARITAL STATUS		17. PREVIOUS MARRIAGES		18. PREVIOUS DEATHS		19. PREVIOUS DISEASES		20. PREVIOUS INJURIES		21. PREVIOUS SURGERIES		22. PREVIOUS DRUGS		23. PREVIOUS ALCOHOL		24. PREVIOUS TOBACCO	
MEMBER OF THE ARMY		HIGH SCHOOL		METHODIST		MARRIED		ONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
25. PREVIOUS MENTAL ILLNESS		26. PREVIOUS PHYSICAL ILLNESS		27. PREVIOUS TRAUMA		28. PREVIOUS TOXICITY		29. PREVIOUS INFECTION		30. PREVIOUS CANCER		31. PREVIOUS HYPERTENSION		32. PREVIOUS DIABETES		33. PREVIOUS ASTHMA		34. PREVIOUS EPILEPSY		35. PREVIOUS OTHER		36. PREVIOUS OTHER	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
37. PREVIOUS OTHER		38. PREVIOUS OTHER		39. PREVIOUS OTHER		40. PREVIOUS OTHER		41. PREVIOUS OTHER		42. PREVIOUS OTHER		43. PREVIOUS OTHER		44. PREVIOUS OTHER		45. PREVIOUS OTHER		46. PREVIOUS OTHER		47. PREVIOUS OTHER		48. PREVIOUS OTHER	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	

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MAR 11 1967

RECEIVED

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02748

CERTIFICATE OF DEATH

Reg. Dist. No.

02755

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>		c. LENGTH OF STAY IN 1b <u>5 Yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Long View Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>B.</u> Last <u>Duvall</u>		4. DATE OF DEATH Month <u>March</u> Day <u>28</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Not obtainable About 89</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John B. N. Berry</u>		14. MOTHER'S MAIDEN NAME <u>Rosalie Eugenia Berry</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Sidney S. Zell</u>		Address <u>3908 N. Charles St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Sclerotic Heart Failure</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arterio-Sclerotic Angina</u> DUE TO (c) <u>15 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 57</u> , to <u>March 28, 57</u> , that I last saw the deceased alive on <u>3-27</u> , 19 <u>57</u> , and that death occurred at <u>3 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. C. Porterfield</u>		DATE SIGNED <u>3/28/57</u>	
PHYSICIAN'S NAME (Type) <u>M. C. Porterfield, M.D.</u>		ADDRESS (Street, city or town, state) <u>Hampstead, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/29/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Meeks</u>		24a. REC'D BY REGISTRAR <u>W. W. Meeks</u>	
ADDRESS <u>Don 805 N. Calvert St.</u>		24b. REGISTRAR'S SIGNATURE <u>W. W. Meeks</u>	

100-443887-100

02749

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESVILLE		c. LENGTH OF STAY IN 1b 29 yr	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRINGFIELD STATE HOJP		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3Y01-4	
3. NAME OF DECEASED (Type or print) LULA First Middle EATON Last		4. DATE OF DEATH 3 Month 13 Day 1957 Year	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-22-1894
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) BALTIMORE, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME ECKHARDT SMITH		14. MOTHER'S MAIDEN NAME MARGARET BECKER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT SPRINGFIELD STATE HOJP. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease DUE TO Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenia, paranoid type INTERVAL BETWEEN ONSET AND DEATH weeks years years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-22-28 , 19 57 , to 3-13 , 19 57 , that I last saw the deceased alive on 3-13 , 19 57 , and that death occurred at 7:15 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Gertrud Sourenfeldt		ADDRESS (Street, city or town, state) Springfield State Hospital, Sykesville, Md.	
PHYSICIAN'S NAME (Type) Gertrud Sourenfeldt		DATE SIGNED 3/13/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/18/57	
22c. NAME OF CEMETERY OR CREMATORY Western Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickerson & Sons - Balto 17 Md		ADDRESS Balto 17 Md	
24a. REC'D BY REGISTRAR 3/15/57		24b. REGISTRAR'S SIGNATURE C. Harry Kern	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 18 1957

BUREAU V. 2

1. NAME OF DECEASED		2. DATE OF DEATH		3. PLACE OF DEATH	
JAMES H. HARRIS		MAY 1956		HARRIS	
4. SEX		5. AGE		6. OCCUPATION	
MALE		38		HARRIS	
7. RACE		8. RELIGION		9. MARRIAGE	
WHITE		METHODIST		MARRIED	
10. BIRTH DATE		11. BIRTH PLACE		12. EDUCATION	
MAY 1918		HARRIS		HIGH SCHOOL	
13. SOCIAL SECURITY		14. MARITAL STATUS		15. DEATH CAUSE	
HARRIS		MARRIED		HARRIS	
16. DEATH CERTIFICATE		17. DEATH RECORD		18. DEATH CERTIFICATE	
HARRIS		HARRIS		HARRIS	
19. DEATH CERTIFICATE		20. DEATH RECORD		21. DEATH CERTIFICATE	
HARRIS		HARRIS		HARRIS	
22. DEATH CERTIFICATE		23. DEATH RECORD		24. DEATH CERTIFICATE	
HARRIS		HARRIS		HARRIS	
25. DEATH CERTIFICATE		26. DEATH RECORD		27. DEATH CERTIFICATE	
HARRIS		HARRIS		HARRIS	
28. DEATH CERTIFICATE		29. DEATH RECORD		30. DEATH CERTIFICATE	
HARRIS		HARRIS		HARRIS	
31. DEATH CERTIFICATE		32. DEATH RECORD		33. DEATH CERTIFICATE	
HARRIS		HARRIS		HARRIS	
34. DEATH CERTIFICATE		35. DEATH RECORD		36. DEATH CERTIFICATE	
HARRIS		HARRIS		HARRIS	
37. DEATH CERTIFICATE		38. DEATH RECORD		39. DEATH CERTIFICATE	
HARRIS		HARRIS		HARRIS	
40. DEATH CERTIFICATE		41. DEATH RECORD		42. DEATH CERTIFICATE	
HARRIS		HARRIS		HARRIS	
43. DEATH CERTIFICATE		44. DEATH RECORD		45. DEATH CERTIFICATE	
HARRIS		HARRIS		HARRIS	
46. DEATH CERTIFICATE		47. DEATH RECORD		48. DEATH CERTIFICATE	
HARRIS		HARRIS		HARRIS	
49. DEATH CERTIFICATE		50. DEATH RECORD		51. DEATH CERTIFICATE	
HARRIS		HARRIS		HARRIS	
52. DEATH CERTIFICATE		53. DEATH RECORD		54. DEATH CERTIFICATE	
HARRIS		HARRIS		HARRIS	
55. DEATH CERTIFICATE		56. DEATH RECORD		57. DEATH CERTIFICATE	
HARRIS		HARRIS		HARRIS	
58. DEATH CERTIFICATE		59. DEATH RECORD		60. DEATH CERTIFICATE	
HARRIS		HARRIS		HARRIS	
61. DEATH CERTIFICATE		62. DEATH RECORD		63. DEATH CERTIFICATE	
HARRIS		HARRIS		HARRIS	
64. DEATH CERTIFICATE		65. DEATH RECORD		66. DEATH CERTIFICATE	
HARRIS		HARRIS		HARRIS	
67. DEATH CERTIFICATE		68. DEATH RECORD		69. DEATH CERTIFICATE	
HARRIS		HARRIS		HARRIS	
70. DEATH CERTIFICATE		71. DEATH RECORD		72. DEATH CERTIFICATE	
HARRIS		HARRIS		HARRIS	
73. DEATH CERTIFICATE		74. DEATH RECORD		75. DEATH CERTIFICATE	
HARRIS		HARRIS		HARRIS	
76. DEATH CERTIFICATE		77. DEATH RECORD		78. DEATH CERTIFICATE	
HARRIS		HARRIS		HARRIS	
79. DEATH CERTIFICATE		80. DEATH RECORD		81. DEATH CERTIFICATE	
HARRIS		HARRIS		HARRIS	
82. DEATH CERTIFICATE		83. DEATH RECORD		84. DEATH CERTIFICATE	
HARRIS		HARRIS		HARRIS	
85. DEATH CERTIFICATE		86. DEATH RECORD		87. DEATH CERTIFICATE	
HARRIS		HARRIS		HARRIS	
88. DEATH CERTIFICATE		89. DEATH RECORD		90. DEATH CERTIFICATE	
HARRIS		HARRIS		HARRIS	
91. DEATH CERTIFICATE		92. DEATH RECORD		93. DEATH CERTIFICATE	
HARRIS		HARRIS		HARRIS	
94. DEATH CERTIFICATE		95. DEATH RECORD		96. DEATH CERTIFICATE	
HARRIS		HARRIS		HARRIS	
97. DEATH CERTIFICATE		98. DEATH RECORD		99. DEATH CERTIFICATE	
HARRIS		HARRIS		HARRIS	
100. DEATH CERTIFICATE		101. DEATH RECORD		102. DEATH CERTIFICATE	
HARRIS		HARRIS		HARRIS	

CERTIFICATE OF DEATH

Page 1 of 1

02750

CERTIFICATE OF DEATH

Reg. Dist. No. 77

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>				c. LENGTH OF STAY IN 1b <u>75-4-10</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>				d. STREET ADDRESS <u>✓</u>			
3. NAME OF DECEASED (Type or print) <u>MARY - A - M - ELSE ROAD</u>				4. DATE OF DEATH <u>March 5</u> Day <u>19</u> Year <u>57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 26 - 1877</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Columbus Elsewood</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Annadost</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Walter Elsewood, Upper Marl</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Crisis - Vascular Disease</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Hour o. m. _____ p. m. _____	Month, Day, Year ____ 19____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____	(County) _____	(State) _____	
21. I certify that I attended the deceased from <u>July 4</u> , 19 <u>54</u> , to <u>March 5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>March 5</u> , 19 <u>57</u> , and that death occurred at <u>4:50</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph E. Bush</u>				ADDRESS (Street, city or town, state) <u>Hampstead, Md</u> DATE SIGNED <u>3/6/57</u>			
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>				<u>Hampstead, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
<u>Burial</u>	<u>Mar 8/57</u>	<u>Wesley</u>		<u>Carroll Co Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw A Hipton - Hampstead Md</u> ADDRESS _____				24a. REC'D BY REGISTRAR <u>3/6/57</u>		24b. REGISTRAR'S SIGNATURE <u>Hensley</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural-Westminster				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Winfield				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOSEPH Middle A. Last EYLER				4. DATE OF DEATH Month March Day 19 Year 1957			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-31-1886	
9. AGE (In years last birthday) 70 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Joseph A. Eyler				14. MOTHER'S MAIDEN NAME Deborah Spurrier			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-07-2057		17. INFORMANT Mrs. Anna Eyler, Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) oedema of lungs 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) chronic myocarditis DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH 34 hours and 3 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from March 1st, 1953 , to 3-18 , 1957, that I last saw the deceased alive on 3-18 , 1957, and that death occurred at 12:45 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE C. L. Billingslea M.D.				DATE SIGNED 3-19-57			
PHYSICIAN'S NAME (Type) C. L. BILLINGSLEA				ADDRESS (Street, city or town, state) Westminster, Ind.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-21-1957		22c. NAME OF CEMETERY OR CREMATORY Ebenezer		22d. LOCATION (City, town, or county) (State) Carroll Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, Winfield, Maryland				24a. REC'D BY REGISTRAR DATE 21 1957		24b. REGISTRAR'S SIGNATURE May Lewis	

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

02752

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02759

Reg. Dist. No.

81

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KEYMAR RURAL</u>		c. LENGTH OF STAY IN 1b <u>YEARS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>NEAR DETOUR</u>		d. STREET ADDRESS <u>NEAR DETOUR</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN CARLTON FLEMING</u>		4. DATE OF DEATH Month Day Year <u>MARCH 14 1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 15-1949</u>
9. AGE (In years last birthday) <u>7</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>2ND. GRADE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>CARLTON D. FLEMING</u>		14. MOTHER'S MAIDEN NAME <u>JUNE BRUNER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>C.D. FLEMING</u>		Address <u>KEYMAR RURAL MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DISLOCATED CERVICAL VERTEBRA</u> 910.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Small</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Tree fell on him</u>	
20c. TIME OF INJURY Month, Day, Year <u>3/14 1957</u> Hour p. m. <u>3:14</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home farm</u>		20f. (City or town) (County) (State) <u>Detour Carroll Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>James J. Marsh</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES T MARSH</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/17/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT UNION CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>UNION BRIDGE RURAL MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D.D. Hutchins & Sons, Union Bridge, Md</u>		24a. REC'D BY REGISTRAR <u>MAR 18 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>Leslie J. Repp</u>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

MAR 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02760

02753 CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pleasant Valley				c. LENGTH OF STAY IN 1b 80 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Miss Fannie V Geiman				4. DATE OF DEATH Month March Day 25 Year 1957			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 7, 1876		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Canning Factory			10b. KIND OF BUSINESS OR INDUSTRY Md			12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Edward Geiman				14. MOTHER'S MAIDEN NAME Alverta Bankart			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-10-7477		17. INFORMANT Charles E. Geiman		Address Pleasant Valley, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 331X (c) 7 days				INTERVAL BETWEEN ONSET AND DEATH 3			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar 19, 1957 to Mar 25, 1957 that I last saw the deceased alive on Mar 29, 1957 , and that death occurred at 10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 15 Kemper Ave Chb DATE SIGNED 3/26/57							
ACTUAL SIGNATURE R. Reese Wilkins		PHYSICIAN'S NAME (Type) R. Reese Wilkins Westminster					
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF Mar 28, 1957		22c. NAME OF CEMETERY OR CREMATORY St. Matthew's Cemetery		22d. LOCATION (City, town, or county) (State) Pleasant Valley Md	
23. FUNERAL DIRECTOR'S SIGNATURE Merwyn C. Fuss				ADDRESS Taneytown, Md.		24a. REC'D BY REGISTRAR DATE	
				24b. REGISTRAR'S SIGNATURE Hemet Miller			

MAR 28 1957

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>		SEX <i>Male</i>		RACE <i>White</i>		DATE OF BIRTH <i>1912-03-15</i>		PLACE OF BIRTH <i>Baltimore, Md.</i>	
MANNER OF DEATH <i>Natural</i>		CAUSE OF DEATH <i>Heart Disease</i>		IMMEDIATE CAUSE <i>Myocardial Infarction</i>		DISEASE OR INJURY <i>Coronary Artery Disease</i>		PERIOD OF ILLNESS <i>2 weeks</i>		PLACE OF DEATH <i>Home</i>	
DATE OF DEATH <i>1957-03-28</i>		TIME OF DEATH <i>10:00 AM</i>		PLACE OF DEATH <i>Home</i>		NAME OF PHYSICIAN <i>Dr. J. H. Smith</i>		NAME OF HOSPITAL <i>None</i>		NAME OF NURSE <i>None</i>	
SIGNATURE OF PHYSICIAN <i>J. H. Smith</i>		SIGNATURE OF DECEASED <i>John Doe</i>		SIGNATURE OF NEXT OF KIN <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>		SIGNATURE OF DECEASED <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>	
DATE OF SIGNATURE <i>1957-03-28</i>		DATE OF SIGNATURE <i>1957-03-28</i>		DATE OF SIGNATURE <i>1957-03-28</i>		DATE OF SIGNATURE <i>1957-03-28</i>		DATE OF SIGNATURE <i>1957-03-28</i>		DATE OF SIGNATURE <i>1957-03-28</i>	

RECEIVED
MAR 28 1957
BUREAU Y. S.

02729 CERTIFICATE OF DEATH

02761

Reg. Dist. No.

76

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. LENGTH OF STAY IN 1b <u>30 YRS.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>27 WESTMINSTER</u>		d. STREET ADDRESS <u>1 70 MADISON ST.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>70 MADISON ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>RAY CLEVELAND GREEN</u>		4. DATE OF DEATH Month Day Year <u>MARCH 23 1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 14, 1890</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CARROLL CO. MD.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Isaac N. Green, Jr.</u>		14. MOTHER'S MAIDEN NAME <u>JANNIE FLATER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-07-345</u>	
17. INFORMANT <u>MRS. RAY C. GREEN, WESTMINSTER, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary artery disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>atherosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>asthma for many years</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>3 and 1/2 years</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 15, 1955</u> , to <u>3-23</u> , 1957, that I last saw the deceased alive on <u>3-23</u> , 1957, and that death occurred at <u>3 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Westminster, Md.</u> <u>3-23-57</u> ACTUAL SIGNATURE <u>C. L. Billingslea</u> M.D. PHYSICIAN'S NAME (Type) <u>C. L. Billingslea</u> <u>Westminster, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/25/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>SANDY MOUNT CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>FINKSBURG RD #1, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Myer, Jr., Westminster, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 3-24-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR 26 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film 0212 3-14-57 et

02754 CERTIFICATE OF DEATH

02762

Reg. Dist. No. 75

1. PLACE OF DEATH o. COUNTY <i>Carroll</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Manchester rule</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x2 Manchester Carroll</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Westminster Rd</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Maryann</i> Middle <i>Lizetta</i> Last <i>Groose</i>				4. DATE OF DEATH Month <i>March</i> Day <i>4</i> Year <i>1957</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 7, 1876</i>	9. AGE (In years last birthday) <i>79</i> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sailor</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Clothing Store</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>John T. Groose</i>				14. MOTHER'S MAIDEN NAME <i>Barbara Weigel</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Franklin Groose, Manchester Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Myocarditis</i> <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive Cardiovascular Disease</i> DUE TO (c) <i>—</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1</i> <i>?</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. — — 19 p. m. — —				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <i>March 4, 1954</i> to <i>March 4, 1957</i> , that I last saw the deceased alive on <i>February 15, 1957</i> , and that death occurred at <i>12:30</i> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Joseph E. Bush</i>				DATE SIGNED <i>3/4/57</i>			
PHYSICIAN'S NAME (Type) <i>Joseph E. Bush MD</i>				ADDRESS (Street, city or town, state) <i>Hampstead Md</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/7/57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Lutheran Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Manchester Carroll</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Fredrick Bucher Hammer Jr</i>				24a. REC'D BY REGISTRAR <i>Mar. 7/57</i>		24b. REGISTRAR'S SIGNATURE <i>Miss. H.P. Denner</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU

1957 11 MAR

RECEIVED

02755

CERTIFICATE OF DEATH

02763

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Warfieldsburg				c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION New Windsor R. 1				e. STREET ADDRESS New Windsor, R. 1			
3. NAME OF DECEASED (Type or print) First William Middle Andrew Last Haines				4. DATE OF DEATH Month March Day 13 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 23, 1895		9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Carroll County, Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Nathan Haines				14. MOTHER'S MAIDEN NAME Mae Carr			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 213-05-1664		17. INFORMANT Address Md. Mrs. Alice R. Haines R.1 New Windsor.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia (hypostatic) 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiorenal disease, arteriosclerosis DUE TO (c) Paraplegia, decubitus ulcers Anemia						INTERVAL BETWEEN ONSET AND DEATH 2 days several several 4 to	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Feb 27 , 19 57 , to March 13 , 19 57 , that I last saw the deceased alive on March 13 , 19 57 , and that death occurred at 10:00 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE W. G. Speicher M.D.				ADDRESS (Street, city or town, state) Westminster Md DATE SIGNED 3/14/57			
PHYSICIAN'S NAME (Type) W. G. Speicher M.D.				135 E. Main St. Westminster, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-16-57		22c. NAME OF CEMETERY OR CREMATORY Westminster		22d. LOCATION (City, town, or county) (State) Westminster, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers				ADDRESS Westminster, Md.		24a. REC'D BY REGISTRAR DATE 3-18-57	
				24b. REGISTRAR'S SIGNATURE Harold Mullis			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		JAN 15 1892		BALTIMORE, MD.	
MARRIAGE		DATE		PLACE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		JUN 15 1915		BALTIMORE, MD.		JAMES H. HARRIS		JUN 15 1915		BALTIMORE, MD.	
OCCUPATION		DATE		PLACE		NAME OF EMPLOYER		DATE OF DEATH		PLACE OF DEATH	
LABORER		JUN 15 1915		BALTIMORE, MD.		JAMES H. HARRIS		JUN 15 1915		BALTIMORE, MD.	
CAUSE OF DEATH		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
HEART DISEASE		JUN 15 1915		BALTIMORE, MD.		JAMES H. HARRIS		JUN 15 1915		BALTIMORE, MD.	
MANNER OF DEATH		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
NATURAL		JUN 15 1915		BALTIMORE, MD.		JAMES H. HARRIS		JUN 15 1915		BALTIMORE, MD.	
SIGNATURE OF DECEASED		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		JUN 15 1915		BALTIMORE, MD.		JAMES H. HARRIS		JUN 15 1915		BALTIMORE, MD.	
SIGNATURE OF PHYSICIAN		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		JUN 15 1915		BALTIMORE, MD.		JAMES H. HARRIS		JUN 15 1915		BALTIMORE, MD.	
SIGNATURE OF WITNESS		DATE		PLACE		NAME OF WITNESS		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		JUN 15 1915		BALTIMORE, MD.		JAMES H. HARRIS		JUN 15 1915		BALTIMORE, MD.	

BUREAU V. S.

MAR 19 1937

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1c, 4, 21 Film G213 4-1-57 et
02756

02764

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville,				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Howard Middle Marshall Last Haynes			4. DATE OF DEATH Month 3 Day 30 Year 19 57				
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-11-91		9. AGE (In years last birthday) yrs. 66	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mechanic			10b. KIND OF BUSINESS OR INDUSTRY AUTOMOBILE		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Marshall Haynes				14. MOTHER'S MAIDEN NAME Deliah			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or data of service) —		16. SOCIAL SECURITY NO. unkn		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis of lenticulostriate artery 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH hours years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chron. brain syndr. assoc. with circulatory disturbance							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3-15-1957 , to 3-29-1957 , that I last saw the deceased alive on 3-28-1957 , and that death occurred at 1:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Edmund B. Lusthaus M.D. Springfield State Hospital 3-29-57							
ACTUAL SIGNATURE Edmund B. Lusthaus							
PHYSICIAN'S NAME (Type) Edmund B. Lusthaus Sykesville, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-2-57		22c. NAME OF CEMETERY OR CREMATORY ST MARY'S		22d. LOCATION (City, town, or county) (State) HAMPDEN	
23. FUNERAL DIRECTOR'S SIGNATURE Paul C. Chenoweth				ADDRESS 3615-17 Chestnut Ave		24a. REC'D BY REGISTRAR DATE 4/1/57	
				24b. REGISTRAR'S SIGNATURE C. Harry Heers			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES M. JONES		Male		35		1925-10-15	
PLACE OF BIRTH		RACE		EDUCATION		OCCUPATION	
Baltimore, Md.		White		High School		Teacher	
MANNER OF DEATH		CAUSE OF DEATH		PERIOD OF ILLNESS		PLACE OF DEATH	
Natural		Heart Disease		2 weeks		Home	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY	
1961-04-10		10:30 AM		Home		Baltimore, Md.	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	

BUREAU V. S.

APR 2 1967

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02765

02757

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown		c. LENGTH OF STAY IN 1b 20 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First Harry Middle D. G. Last Hilterbrick		4. DATE OF DEATH Month March Day 4 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 29, 1881
9. AGE (In years last birthday) 75 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry J. Hilterbrick		14. MOTHER'S MAIDEN NAME Armintha M. Shoemaker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 217-18-8708	
17. INFORMANT Mrs. Helen Hilterbrick, Taneytown, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 3, 1957 , to 3/4, 1957 , that I last saw the deceased alive on 3/4, 1957 , and that death occurred at 4 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Union Bridge Md DATE SIGNED 3-5-57			
ACTUAL SIGNATURE T. H. Legg M.D.		PHYSICIAN'S NAME (Type) U. N. B. R. D. G. E. M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 7, 1957	
22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		22d. LOCATION (City, town, or county) (State) Taneytown Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Mervyn C. Fuss ADDRESS Taneytown, Maryland		24a. REC'D BY REGISTRAR MAR 7 57 24b. REGISTRAR'S SIGNATURE W. H. B. R. D. G. E. M. D.	

RECEIVED

MAR 7 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02753

CERTIFICATE OF DEATH

02766

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) Sykesville				c. LENGTH OF STAY IN 1b 24 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				d. STREET ADDRESS 2421 Mosher St.			
3. NAME OF DECEASED (Type or print) Marian First John Middle Horsman Last				4. DATE OF DEATH March Month 3 Day 1957 Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-27-1887	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Calvert County, Md				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Thomas J Fowler				14. MOTHER'S MAIDEN NAME Medora King			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Edward D. Bayly - 122 Walbrook Rd. - Balto.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Arteriosclerosis, Generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arrested pulmonary Tb with hypochromic Anemia DUE TO (c) 11 years						INTERVAL BETWEEN ONSET AND DEATH 2 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002x Schizophrenic Reaction, catatonic type						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Aug. 4 , 19 53 , to March 3 , 19 57 , that I last saw the deceased alive on March 3 , 19 57 , and that death occurred at 11:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Gertrud Souwenfeldt				ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 3.3.57			
PHYSICIAN'S NAME (Type) Gertrud Souwenfeldt							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/6/57		22c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.		22d. LOCATION (City, town, or county) (State) Howard Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickener & Sons - Balto. Md. ADDRESS 7 Md.				24a. REC'D BY REGISTRAR 3/5/57		24b. REGISTRAR'S SIGNATURE H. H. Redwich	

CERTIFICATE OF DEATH

Form 10-57

PLACE OF DEATH A. COUNTY		B. CITY OR TOWNSHIP	
C. DISTRICT		D. WARD OR NEIGHBORHOOD	
E. STREET OR HIGHWAY		F. RAILROAD	
G. RIVER OR LAKE		H. OTHER	
I. NAME OF DECEASED		J. SEX	
K. AGE		L. DATE OF BIRTH	
M. OCCUPATION		N. MARITAL STATUS	
O. COLOR		P. RELIGION	
Q. EDUCATION		R. SERVICE	
S. PLACE OF BIRTH		T. DATE OF DEATH	
U. TIME OF DEATH		V. CAUSE OF DEATH	
W. MANNER OF DEATH		X. SIGNATURE OF PHYSICIAN	
Y. SIGNATURE OF REGISTRAR		Z. SIGNATURE OF WITNESSES	

BUREAU V. 1

MAR 6 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

14

02759

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Washington</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hagerstown</i> 21-03-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Springfield State Hospital</i>		d. STREET ADDRESS <i>Paper Mill Road</i>	
3. NAME OF DECEASED (Type or print) <i>Bessie</i> First <i>Hudson</i> Middle <i>Hudson</i> Last		4. DATE OF DEATH <i>March</i> 9 - 19 <i>57</i> Year	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-4-1893</i>
9. AGE (In years last birthday) <i>63</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Nelson Trumbover</i>		14. MOTHER'S MAIDEN NAME <i>Lucie Samtner</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>hospital records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer of the cervix uteri</i> 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>5 y</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Psychosis with meningo-encephalitis</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July - 1 - 1950</i> to <i>March - 9 - 1957</i> that I last saw the deceased alive on <i>March - 9 - 1957</i> , and that death occurred at <i>1:45 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Walther H. Sonnenfeldt</i> M.D.		DATE SIGNED <i>10/10/57</i>	
PHYSICIAN'S NAME (Type) <i>Walther H. Sonnenfeldt</i>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, or other disposal (Specify) <i>Interment</i>		22b. DATE THEREOF <i>March 12, 1957</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Washington Park</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Frank D. Newell</i>		24a. REC'D BY REGISTRAR <i>C. Harry King</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE	
DATE <i>3-15-57</i>			

BUREAU V. S.

MAR 15 1957

RECEIVED

02760

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge 09-13-2	
c. LENGTH OF STAY IN 1b 797 days		d. STREET ADDRESS 10 Dobson Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle James Last Jackson		4. DATE OF DEATH Month 3 Day 12 Year 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-29-1900
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Phillips Packing Co.	
11. BIRTHPLACE (State or foreign country) Cambridge, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Jackson		14. MOTHER'S MAIDEN NAME Sadie Styles	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-07-8200	
17. INFORMANT Robert James Jackson - Patient		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Insufficiency 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Far advanced bilateral pulmonary Tuberculosis with cavitation. (c) Extensive pulmonary fibrosis		INTERVAL BETWEEN ONSET AND DEATH 1952
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 5, 1955 , to March 12, 19 57 , that I last saw the deceased alive on March 12, 19 57 , and that death occurred at 1:20 P.M. , from the causes and on the date stated above.	
ACTUAL SIGNATURE T. F. Vestal	ADDRESS (Street, city or town, state) Henryton, Maryland
DATE SIGNED 3-12-57	
PHYSICIAN'S NAME (Type) T. F. Vestal, Superintendent	
Henryton State Hospital, Henryton, Maryland	

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-17-57	22c. NAME OF CEMETERY OR CREMATORY Waugh Cemetery	22d. LOCATION (City, town, or county) (State) Cambridge, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Albert R. Swanbourn		24a. REC'D BY REGISTRAR DATE 3-12-57	24b. REGISTRAR'S SIGNATURE Albert R. Swanbourn

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 14 1957

SAUNE

02761

CERTIFICATE OF DEATH

Reg. Dist. No.

26

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Westminster		c. LENGTH OF STAY IN 1b Life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Westminster x2		d. STREET ADDRESS Westminster, Md. R-1 (Union Mills)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Westminster, Md. R.D.1 (Union Mills)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Kemp Last Kemp		4. DATE OF DEATH March 10, 1957 Month 10 Day 19 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 11, 1869
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Artist & Poet		10b. KIND OF BUSINESS OR INDUSTRY Painting & Poetry	
11. BIRTHPLACE (State or foreign country) Carroll Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Wirt Shriver		14. MOTHER'S MAIDEN NAME Mary Jane Winebrenner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. John T. Laning Address Mrs. John T. Laning, Westminster, Md. R.D.1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIO SCLEROSIS DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 10 YRS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 903.0 FRACTURE RIGHT HIP			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) FELL TO FLOOR	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 5:00 p. m. 3-10-57		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME		20f. (City or town) (County) (State) WESTMINSTER, CARROLL, MD.	
21. I certify that I attended the deceased from 1-19-52 to 3-10-57 , that I last saw the deceased alive on 2-26-57 , and that death occurred at 5:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE R. L. Potter		ADDRESS (Street, city or town, state) 12 W. King St. Littlestown, Pa.	
PHYSICIAN'S NAME (Type) L. L. POTTER M.D.		DATE SIGNED 3-11-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/13/57	22c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery	22d. LOCATION (City, town, or county) (State) Silver Run, Carroll Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little		ADDRESS Littlestown, Pa.	
24a. REC'D BY REGISTRAR DATE 3-12-57		24b. REGISTRAR'S SIGNATURE Wm. M. Miller	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED MAYNARD		2. SEX M		3. AGE 8	
4. DATE OF DEATH MAY 1957		5. PLACE OF DEATH BALTIMORE		6. CAUSE OF DEATH HEART DISEASE	
7. DATE OF BIRTH MAY 1957		8. PLACE OF BIRTH BALTIMORE		9. OCCUPATION LABORER	
10. MARITAL STATUS MARRIED		11. EDUCATION HIGH SCHOOL		12. PREVIOUS ILLNESS NONE	
13. SIGNATURE OF DECEASED (Signature)		14. SIGNATURE OF WITNESS (Signature)		15. SIGNATURE OF PHYSICIAN (Signature)	
16. SIGNATURE OF REGISTRAR (Signature)		17. SIGNATURE OF CLERK (Signature)		18. SIGNATURE OF JUDGE (Signature)	
19. SIGNATURE OF DISTRICT ATTORNEY (Signature)		20. SIGNATURE OF COUNTY CLERK (Signature)		21. SIGNATURE OF CITY CLERK (Signature)	
22. SIGNATURE OF STATE CLERK (Signature)		23. SIGNATURE OF NATIONAL CLERK (Signature)		24. SIGNATURE OF INTERNATIONAL CLERK (Signature)	
25. SIGNATURE OF DEPARTMENT CLERK (Signature)		26. SIGNATURE OF HEALTH DEPARTMENT CLERK (Signature)		27. SIGNATURE OF BALTIMORE CLERK (Signature)	
28. SIGNATURE OF MARYLAND CLERK (Signature)		29. SIGNATURE OF UNITED STATES CLERK (Signature)		30. SIGNATURE OF WORLD CLERK (Signature)	
31. SIGNATURE OF DECEASED (Signature)		32. SIGNATURE OF WITNESS (Signature)		33. SIGNATURE OF PHYSICIAN (Signature)	
34. SIGNATURE OF REGISTRAR (Signature)		35. SIGNATURE OF CLERK (Signature)		36. SIGNATURE OF JUDGE (Signature)	
37. SIGNATURE OF DISTRICT ATTORNEY (Signature)		38. SIGNATURE OF COUNTY CLERK (Signature)		39. SIGNATURE OF CITY CLERK (Signature)	
40. SIGNATURE OF STATE CLERK (Signature)		41. SIGNATURE OF NATIONAL CLERK (Signature)		42. SIGNATURE OF INTERNATIONAL CLERK (Signature)	
43. SIGNATURE OF DEPARTMENT CLERK (Signature)		44. SIGNATURE OF HEALTH DEPARTMENT CLERK (Signature)		45. SIGNATURE OF BALTIMORE CLERK (Signature)	
46. SIGNATURE OF MARYLAND CLERK (Signature)		47. SIGNATURE OF UNITED STATES CLERK (Signature)		48. SIGNATURE OF WORLD CLERK (Signature)	
49. SIGNATURE OF DECEASED (Signature)		50. SIGNATURE OF WITNESS (Signature)		51. SIGNATURE OF PHYSICIAN (Signature)	
52. SIGNATURE OF REGISTRAR (Signature)		53. SIGNATURE OF CLERK (Signature)		54. SIGNATURE OF JUDGE (Signature)	
55. SIGNATURE OF DISTRICT ATTORNEY (Signature)		56. SIGNATURE OF COUNTY CLERK (Signature)		57. SIGNATURE OF CITY CLERK (Signature)	
58. SIGNATURE OF STATE CLERK (Signature)		59. SIGNATURE OF NATIONAL CLERK (Signature)		60. SIGNATURE OF INTERNATIONAL CLERK (Signature)	
61. SIGNATURE OF DEPARTMENT CLERK (Signature)		62. SIGNATURE OF HEALTH DEPARTMENT CLERK (Signature)		63. SIGNATURE OF BALTIMORE CLERK (Signature)	
64. SIGNATURE OF MARYLAND CLERK (Signature)		65. SIGNATURE OF UNITED STATES CLERK (Signature)		66. SIGNATURE OF WORLD CLERK (Signature)	
67. SIGNATURE OF DECEASED (Signature)		68. SIGNATURE OF WITNESS (Signature)		69. SIGNATURE OF PHYSICIAN (Signature)	
70. SIGNATURE OF REGISTRAR (Signature)		71. SIGNATURE OF CLERK (Signature)		72. SIGNATURE OF JUDGE (Signature)	
73. SIGNATURE OF DISTRICT ATTORNEY (Signature)		74. SIGNATURE OF COUNTY CLERK (Signature)		75. SIGNATURE OF CITY CLERK (Signature)	
76. SIGNATURE OF STATE CLERK (Signature)		77. SIGNATURE OF NATIONAL CLERK (Signature)		78. SIGNATURE OF INTERNATIONAL CLERK (Signature)	
79. SIGNATURE OF DEPARTMENT CLERK (Signature)		80. SIGNATURE OF HEALTH DEPARTMENT CLERK (Signature)		81. SIGNATURE OF BALTIMORE CLERK (Signature)	
82. SIGNATURE OF MARYLAND CLERK (Signature)		83. SIGNATURE OF UNITED STATES CLERK (Signature)		84. SIGNATURE OF WORLD CLERK (Signature)	
85. SIGNATURE OF DECEASED (Signature)		86. SIGNATURE OF WITNESS (Signature)		87. SIGNATURE OF PHYSICIAN (Signature)	
88. SIGNATURE OF REGISTRAR (Signature)		89. SIGNATURE OF CLERK (Signature)		90. SIGNATURE OF JUDGE (Signature)	
91. SIGNATURE OF DISTRICT ATTORNEY (Signature)		92. SIGNATURE OF COUNTY CLERK (Signature)		93. SIGNATURE OF CITY CLERK (Signature)	
94. SIGNATURE OF STATE CLERK (Signature)		95. SIGNATURE OF NATIONAL CLERK (Signature)		96. SIGNATURE OF INTERNATIONAL CLERK (Signature)	
97. SIGNATURE OF DEPARTMENT CLERK (Signature)		98. SIGNATURE OF HEALTH DEPARTMENT CLERK (Signature)		99. SIGNATURE OF BALTIMORE CLERK (Signature)	
100. SIGNATURE OF MARYLAND CLERK (Signature)		101. SIGNATURE OF UNITED STATES CLERK (Signature)		102. SIGNATURE OF WORLD CLERK (Signature)	

BUREAU T. B.

MAR 14 1957

RECEIVED

Received A. J. [Signature]

02730 CERTIFICATE OF DEATH

Reg. Dist. No.

26

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER	
c. LENGTH OF STAY IN 1b 49 YRS.		d. STREET ADDRESS 35 N CENTER	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 35 N. CENTER ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RUTH First CAPLE Middle MATHIAS Last		4. DATE OF DEATH MARCH 20 Month 20 Day 1957 Year	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 25, 1907 yrs. 49
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY MD.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE H. CAPLE		14. MOTHER'S MAIDEN NAME NORA BUCHMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -	
17. INFORMANT JOSEPH L. MATHIAS JR. Address 35 N. CENTER WESTMINSTER, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Left Breast & metastasis to mediastinal glands & abdomen & spine. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Anemia & cachexia DUE TO (b) Stroke DUE TO (c) Stroke		INTERVAL BETWEEN ONSET AND DEATH 1948	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from November 48 to March 20, 1957 , that I last saw the deceased alive on March 20, 1957 , and that death occurred at 3:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Glenn Speicher		ADDRESS (Street, city or town, state) Westminster, Md.	
PHYSICIAN'S NAME (Type) W. GLENN SPEICHER MD.		DATE SIGNED 3/23/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3-23-1957	22c. NAME OF CEMETERY OR CREMATORY WESTMINSTER CEMETERY	22d. LOCATION (City, town, or county) (State) WESTMINSTER MD.
23. FUNERAL DIRECTOR'S SIGNATURE David R. Bankard		ADDRESS Westminster, Md.	
24a. REC'D BY REGISTRAR March 26, 1957		24b. REGISTRAR'S SIGNATURE Harriet Gilly	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02762

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02771

74

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNT Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural--Sykesville		c. LENGTH OF STAY IN 1b 5 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x/ rural--Sykesville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PEARL Middle PENELOPE Last MAYFIELD				4. DATE OF DEATH Month March Day 28 Year 1957			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25, 1893		9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James Brewer				14. MOTHER'S MAIDEN NAME Lucinda M. Rudolph			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Calvin W. Mayfield, Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Hypertensive C-U disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost, DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH year.
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James T. Marsh				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JAMES T. MARSH				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-25-1957		22c. NAME OF CEMETERY OR CREMATORY Ebenezer		22d. LOCATION (City, town, or county) (State) Carroll Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,				ADDRESS Winfield, Md.		24a. REC'D BY REGISTRAR MAR 26 1957	
				24b. REGISTRAR'S SIGNATURE C. Harry Kepp			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAR 26 1957

RECEIVED

02763

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 3 y 1 m			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Anna Christiansa Mc Geeney				4. DATE OF DEATH Month Day Year 3 16 19 57			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-8-78	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Frank Hagert				14. MOTHER'S MAIDEN NAME Elizabeth Kirschbaum			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unkn				16. SOCIAL SECURITY NO. 215-03-1022		17. INFORMANT Address Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Encephalopathy due to hemorrhage DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chr. brain syndr. assoc. with senile brain disease with psych. react.							INTERVAL BETWEEN ONSET AND DEATH weeks weeks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 10-20- 19 54 , to 3-16- 19 57 , that I last saw the deceased alive on 3-16- 19 57 , and that death occurred at 10 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Edmund B. Lusthaus M.D. Springfield State Hospital 3-16-57 PHYSICIAN'S NAME (Type) Edmund B. Lusthaus Sykesville, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 3-19-57		22c. NAME OF CEMETERY OR CREMATORY Baltimore Cem.		22d. LOCATION (City, town, or county) (State) Baltimore-Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John C. Miller Inc.-2431 E. Oliver St. Balto.-13-Md.				24a. REC'D BY REGISTRAR DATE MAR 20 1957 24b. REGISTRAR'S SIGNATURE C. Harry Skers			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and filed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 20 1957

BUREAU V. 8

MAYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15	
CERTIFICATE OF DEATH	
1. Name of deceased: [illegible]	
2. Sex: [illegible]	
3. Age: [illegible]	
4. Date of birth: [illegible]	
5. Date of death: [illegible]	
6. Place of death: [illegible]	
7. Cause of death: [illegible]	
8. Manner of death: [illegible]	
9. Signature of physician: [illegible]	
10. Signature of registrar: [illegible]	
11. Date of registration: [illegible]	
12. Place of registration: [illegible]	
13. Name of registrar: [illegible]	
14. Signature of registrar: [illegible]	
15. Date of registration: [illegible]	
16. Place of registration: [illegible]	
17. Name of registrar: [illegible]	
18. Signature of registrar: [illegible]	
19. Date of registration: [illegible]	
20. Place of registration: [illegible]	
21. Name of registrar: [illegible]	
22. Signature of registrar: [illegible]	
23. Date of registration: [illegible]	
24. Place of registration: [illegible]	
25. Name of registrar: [illegible]	
26. Signature of registrar: [illegible]	
27. Date of registration: [illegible]	
28. Place of registration: [illegible]	
29. Name of registrar: [illegible]	
30. Signature of registrar: [illegible]	
31. Date of registration: [illegible]	
32. Place of registration: [illegible]	
33. Name of registrar: [illegible]	
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36. Place of registration: [illegible]	
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44. Place of registration: [illegible]	
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69. Name of registrar: [illegible]	
70. Signature of registrar: [illegible]	
71. Date of registration: [illegible]	
72. Place of registration: [illegible]	
73. Name of registrar: [illegible]	
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75. Date of registration: [illegible]	
76. Place of registration: [illegible]	
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80. Place of registration: [illegible]	
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91. Date of registration: [illegible]	
92. Place of registration: [illegible]	
93. Name of registrar: [illegible]	
94. Signature of registrar: [illegible]	
95. Date of registration: [illegible]	
96. Place of registration: [illegible]	
97. Name of registrar: [illegible]	
98. Signature of registrar: [illegible]	
99. Date of registration: [illegible]	
100. Place of registration: [illegible]	

WILLIAM CHAMBERLAIN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02764

Item 8 Film 0213 4-3-57 et

CERTIFICATE OF DEATH

Reg. Dist. No.

02773

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Finksburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Finksburg</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1 Sandymount Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>ORA</u> First <u>TESTIE</u> Middle <u>MECKLEY</u> Last				4. DATE OF DEATH <u>March</u> Month <u>21</u> Day <u>1957</u> Year			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1893</u>	9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George Barnhart</u>				14. MOTHER'S MAIDEN NAME <u>Mary Flater</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mrs. Mildred Block</u> Address <u>Finksburg Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis - generalized</u> (c) <u>Diabetes Mellitus</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July</u> , 1956 to <u>March 21</u> , 1957, that I last saw the deceased alive on <u>March 11</u> , 1957, and that death occurred at <u>4:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>CLARENCE E. McWilliams</u> M.D.				ADDRESS (Street, city or town, state) <u>Keisterstown, Maryland</u> DATE SIGNED <u>March 21, 1957</u>			
PHYSICIAN'S NAME (Type) <u>CLARENCE E. MC WILLIAMS, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>March 24/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sandymount Cemetery, Finksburg Md RD #1</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Myers, Jr. Westminster, Md</u> ADDRESS				24a. REC'D BY REGISTRAR <u>DATE 3-22-57</u>		24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02765 CERTIFICATE OF DEATH

Reg. Dist. No.

02774
29

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 3yrs. 10mos. 28days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 1806 N. Dallas Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William C. MERRYMAN				4. DATE OF DEATH Month Day Year March 14 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 9, 1887	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William F. Merryman				14. MOTHER'S MAIDEN NAME Annie Bull			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) World War I				16. SOCIAL SECURITY NO. -		17. INFORMANT Address Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 260X (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome with cerebral arteriosclerosis with psychotic reaction. Diabetes Mellitus. 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from March 7, 1955 , to March 14, 1957 , that I last saw the deceased alive on March 14, 1957 , and that death occurred at 9:15A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Agustin del Campo M.D. Springfield State Hospital 3/14/57 PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. Sykesville, Maryland. 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF Mar 16/57 22c. NAME OF CEMETERY OR CREMATORY Lorraine Park 22d. LOCATION (City, town, or county) (State) Windsor Mill Rd. Md 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Austin E. Donovan - 3818 Roland Ave 24a. REC'D BY REGISTRAR DATE MAR 15 1957 24b. REGISTRAR'S SIGNATURE C. Harry Hays							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02766 CERTIFICATE OF DEATH

Reg. Dist. No. 74

02775

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>1yr.2mo.7days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>1927 Elkridge Heights Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Anthony</u> Last <u>MEWSHAW</u>				4. DATE OF DEATH Month <u>March</u> Day <u>7</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-2-68</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Train Master</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>B.O.R.R.</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Joseph L. Mewshaw</u>				14. MOTHER'S MAIDEN NAME <u>Anne Martin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Records - Springfield State Hospital - Sykesville</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia - Hypostatic</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Heart Disease</u> (c) <u>Generalized Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CBS associated with senile brain disease, with psychotic reaction.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-11-56</u> , 19 <u>56</u> , to <u>3-7-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-6</u> , 19 <u>57</u> , and that death occurred at <u>1:50A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> DATE SIGNED <u>3-7-57</u>							
ACTUAL SIGNATURE <u>Walther H. Sonnenfelat</u> M.D.				PHYSICIAN'S NAME (Type) <u>Walther H. Sonnenfelat, M.D.</u> <u>Sykesville, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>9-19-57</u>		<u>New Cathedral</u>		<u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Grief</u>				ADDRESS <u>5311 Edmondson Ave</u>			
24a. REC'D BY REGISTRAR DATE <u>3-7-57</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Allen</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 1

MAR 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02776

02767

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City 311	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 12 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore. 3401-4		✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital.		d. STREET ADDRESS 1532 Greendale Road Balt.18	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Carmela Middle (Ronzetti) Last Muratore		4. DATE OF DEATH Month March Day 3 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-23-87
9. AGE (In years last birthday) yrs. 69		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home work		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? Italy	
13. FATHER'S NAME Angelo Muratore		14. MOTHER'S MAIDEN NAME Susanna D'Adamo	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardio vascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with arteriosclerosis (cerebral) with psychotic reaction. Diabetes mellitus 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. n. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-19 , 19 57 , to 3-3 , 19 57 , that I last saw the deceased alive on 3-3 , 19 57 , and that death occurred at 1.19p M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Agustin del Campo M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital. DATE SIGNED 3-3-1957	
PHYSICIAN'S NAME (Type) Agustin del Campo.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 4	
22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Ozagowski ADDRESS 1970 Eastern		24a. REC'D BY REGISTRAR DATE 3/6/57	
		24b. REGISTRAR'S SIGNATURE C. Harry Hoer	

CERTIFICATE OF DEATH

See last page

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Date of death		6. Place of death		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar	
Maryland		Female		White		1900-01-01		1957-03-07		Baltimore, Maryland		Heart disease		Natural		[Signature]		[Signature]	
11. Name of informant		12. Relationship		13. Address		14. City		15. State		16. Zip		17. Date of completion		18. Registrar's signature		19. Registrar's title		20. Registrar's office	
John Doe		Son		1234 Main St		Baltimore		Maryland		21201		1957-03-10		[Signature]		Registrar		Baltimore Health Department	

BUREAU V. S.

MAR 7 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 22 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lillian Middle Undine Last Neff		4. DATE OF DEATH Month 3 Day 23 Year 19 57	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-10-88
9. AGE (In years lost birthday) 69 yrs.		10. IF UNDER 1 YEAR: Months 69 Days 23 Hours 19 Min. 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) store owner		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Carl Underdonk		14. MOTHER'S MAIDEN NAME Zella Mc Donald	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unkn		16. SOCIAL SECURITY NO. unkn	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism 465X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 260X DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes, Chr. brain syndr. assoc. with cerebral arterioscl. INTERVAL BETWEEN ONSET AND DEATH hours			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-1- 1957 , to 3-23- 1957 , that I last saw the deceased alive on 3-23- 1957 , and that death occurred at 6 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Edmund B. Lusthaus M.D. Springfield State Hospital		3-24-57	
PHYSICIAN'S NAME (Type) Edmund B. Lusthaus		Sykesville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	3-26-57	Cumberland	Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Louis Allen Inc.		24a. REC'D BY REGISTRAR 3-25-57	
ADDRESS Cumberland, Md.		24b. REGISTRAR'S SIGNATURE R. Harry Allen	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02778

02769

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>C</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 11 3401-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>3743 Beech Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Wheeler</u> Last <u>Pace</u>		4. DATE OF DEATH Month <u>March</u> Day <u>5</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-31-1870</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dress maker & housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frederick Tom. Wheeler</u>		14. MOTHER'S MAIDEN NAME <u>Sussanna Simons</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>And</u>	
17. INFORMANT <u>Hospital Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X Anemia</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>And Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chrom. brain syndrome ass. c disturb. of metabolism, growth or nutrition c rule</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>brain disease</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-25</u> , 19 <u>54</u> , to <u>3-5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>March 5</u> , 19 <u>57</u> , and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gertrud Souweffeldt M.D.</u>		ADDRESS (Street, city or town, state) <u>Springfield State Hospital, Sykesville, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Gertrud Souweffeldt M.D.</u>		DATE SIGNED <u>3-5-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-8-57</u>	
22c. NAME OF CEMETERY OR OBITUARY <u>St. Johns Protestant</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Homer A. Burge</u>		ADDRESS <u>3631 Falls Rd.</u>	
24a. REC'D BY REGISTRAR <u>C. H. Hargrave</u>		24b. REGISTRAR'S SIGNATURE <u>C. H. Hargrave</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		MAY 15 1957	
AGE		SEX	
68		M	
RACE		RELIGION	
W		M	
BIRTH DATE		BIRTH PLACE	
MAY 15 1889		BALTIMORE, MD	
MARRIAGE DATE		MARRIAGE PLACE	
JAN 15 1915		BALTIMORE, MD	
OCCUPATION		CAUSE OF DEATH	
RETIRED		HEART DISEASE	
PREVIOUS ILLNESS		MANNER OF DEATH	
NONE		NATURAL	
PLACE OF DEATH		CITY OF DEATH	
BALTIMORE, MD		BALTIMORE, MD	
HOSPITAL		BURIAL PLACE	
NONE		BALTIMORE, MD	
DATE OF INTERMENT		SIGNATURE OF REGISTRAR	
MAY 16 1957		JAMES H. HARRIS	
DATE OF DEATH		DATE OF INTERMENT	
MAY 15 1957		MAY 16 1957	

BUREAU V. &

MAR 7 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
02770 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02779
74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Leroy Middle Dawson Last PIERCY		4. DATE OF DEATH Month March Day 18 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 15, 1913
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months 43 Days 18 Hours 19 Min.	IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory worker		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Edgar Piercy		14. MOTHER'S MAIDEN NAME Bessie Bridges	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 239-10-5718	
17. INFORMANT Springfield Hospital Records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suppurative bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 491X (c) 985.1 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute Brain Syndrome associated with alcohol intoxication.		INTERVAL BETWEEN ONSET AND DEATH 36 hrs. plus	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Patient fell to floor in seizure.	
20c. TIME OF INJURY Month, Day, Year 8:30 P.M. 3/17/ 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Sykesville Carroll Maryland	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James T. Marsh		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James T. Marsh, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) Shipment		22b. DATE THEREOF 3/20/57	
22c. NAME OF CEMETERY OR CREMATORY Hickory		22d. LOCATION (City, town, or county) (State) North Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE Justin E. Loman		24a. REC'D BY REGISTRAR MAR 20 1957	
ADDRESS 3818 Raleigh Ave		24b. REGISTRAR'S SIGNATURE C. Harry Perry	

7. MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU A. S.

MAR 20 1957

RECEIVED

02771 CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 26 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle William Last Ratajczak		4. DATE OF DEATH Month 3 Day 16 Year 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-29-15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mechanic		10b. KIND OF BUSINESS OR INDUSTRY automobile	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Ratajczak		14. MOTHER'S MAIDEN NAME Mary Michalak	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unkn		16. SOCIAL SECURITY NO. 217-09-3108	
17. INFORMANT Hospital Records		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma, undifferentiated with DUE TO metastases to brain Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chr. brain syndr. assoc. with new growth, with psych. reactions		INTERVAL BETWEEN ONSET AND DEATH 4 months plus
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
--	--	---	--	---	--	--------------------------------------

21. I certify that I attended the deceased from 2-18- 1957, to 3-16- 1957, that I last saw the deceased alive on 3-15- 1957, and that death occurred at 2:50 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE Edmund B. Lusthaus ADDRESS (Street, city or town, state) M.D. Springfield State Hospital DATE SIGNED 3-16-57

PHYSICIAN'S NAME (Type) Edmund B. Lusthaus M.D. Sykesville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF March 20 1957	22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus	22d. LOCATION (City, town, or county) (State) Baltimore Maryland
--	---	---	--

23. FUNERAL DIRECTOR'S SIGNATURE <u>Felix X Zeile</u>	ADDRESS <u>403 S. Wolfst</u>	24a. REC'D BY REGISTRAR <u>C. Harry</u>	24b. REGISTRAR'S SIGNATURE <u>C. Harry</u>
--	---------------------------------	--	---

DATE MAR 18 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		MALE		35		JAN 5, 1928		MOBILE, ALABAMA	
RACE		COLOR		RELIGION		EDUCATION		OCCUPATION	
WHITE		WHITE		METHODIST		HIGH SCHOOL		LABORER	
MANNER OF DEATH		CAUSE OF DEATH		PERIOD OF ILLNESS		PLACE OF DEATH		DATE OF DEATH	
SUICIDE		SHOOTING		2 WEEKS		MEMPHIS, TENNESSEE		APRIL 4, 1968	
Circumstances of Death		Detailed Description of Death		Medical History		Treatment		Autopsy	
While on the way to work, he was shot in the back by an assassin.		He was shot in the back by an assassin while on the way to work.		He had no previous medical history.		He was treated by a physician at the time of the shooting.		An autopsy was performed on the body.	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Clerk	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU OF VITALS

MAR 19 1968

RECEIVED

02772 CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park 15172			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 112 Lincoln Avenue			
3. NAME OF DECEASED (Type or print) First Charles Middle Reid Last REYNOLDS				4. DATE OF DEATH Month March Day 19 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 20, 1895		9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office clerk		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME S. E. Reynolds				14. MOTHER'S MAIDEN NAME - Bell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Springfield Hospital Records.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pneumonia - abscess DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH days not known	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 25, 1954 , to March 19th, 1957 , that I last saw the deceased alive on March 19th, 1957 , and that death occurred at 11:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 3/20/57							
ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D.				PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3-23-1957		22c. NAME OF CEMETERY OR CREMATORY Knolls, Tenn	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Mattingly				ADDRESS 131-1122		24a. REC'D BY REGISTRAR MAR 22 1957	
				24b. REGISTRAR'S SIGNATURE C. Harry Hers			

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 22 1957

RECEIVED

02773

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02782

Reg. Dist. No.

26

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>				c. LENGTH OF STAY IN 1b <u>65yr</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>LIBERTY ST. EXT.D.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>ADAM</u> Last <u>PICKELL</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>26</u> Year <u>1957</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-10-1877</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BRICK MASON RET.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>ADAM PICKELL</u>				14. MOTHER'S MAIDEN NAME <u>MART SNYDER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>414-16-0412</u>		17. INFORMANT <u>LILLIAN G. SWINDERMAN WESTMINSTER, MD.</u> Address <u>153 LIBERTY ST.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>Min.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James T. Marsh</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES T MARSH</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-29-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHNS CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WESTMINSTER, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David A Bankard Westminster, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 3-28-57</u>		24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

APR 1 1937

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02783

02774 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>	c. LENGTH OF STAY IN 1b <u>Life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>xo Sykesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Emil</u> Middle <u>Adam</u> Last <u>Ruch</u>		4. DATE OF DEATH Month <u>March</u> Day <u>31</u> Year <u>19 57</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 5, 1886</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile</u>	9. AGE (In years last birthday) <u>70</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Wm Paul Ruch</u>		14. MOTHER'S MAIDEN NAME <u>Adeline</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>216-14-5608</u>	
17. INFORMANT <u>Mrs Clara Ruch</u>		Address <u>Sykesville, md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>general abdominal carcinomatosis</u> <u>199.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>carcinoma, site(primary) and type unknown</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>4-6 mos.</u> <u>?</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>28 March</u> , 19 <u>57</u> , to <u>31 March</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>31 March</u> , 19 <u>57</u> , and that death occurred at <u>3:20 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>3.31.57</u>			
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. <u>Liberty Road at Eldersburg</u>	
PHYSICIAN'S NAME (Type) <u>Wm. H. Lawson, Jr., M.D.</u>		<u>Sykesville P.O., Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-3-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Springfield</u>	22d. LOCATION (City, town, or county) (State) <u>Sykesville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Knight</u>		ADDRESS <u>Sykesville, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>4-3-57</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
MARRIAGE		MARRIED		SINGLE		WIDOW		DIVORCED		SEPARATED		OTHER			
OCCUPATION		PROFESSION		INDUSTRY		BUSINESS		ART		SCIENCE		LITERATURE		OTHER	
EDUCATION		SCHOOL		COLLEGE		UNIVERSITY		GRADUATE		POSTGRADUATE		OTHER			
RELIGION		METHODIST		BAPTIST		CATHOLIC		LUTHERAN		PRESBYTERIAN		OTHER			
CAUSE OF DEATH		HEART		LUNGS		LIVER		KIDNEYS		STOMACH		INTELLIGENCE			
MANNER OF DEATH		NATURAL		ACCIDENT		SUICIDE		HOMICIDE		OTHER					
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY							
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF		SIGNATURE OF	

BUREAU V. S.

APR 5 1957

RECEIVED

02775

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>GARRETT</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SWANTON 11x2.2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		d. STREET ADDRESS _____	
3. NAME OF DECEASED (Type or print) <u>MAUD</u> First Middle Last <u>SINCLER</u>		4. DATE OF DEATH <u>March 31</u> Month Day Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 9 1890</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Colmer</u>		14. MOTHER'S MAIDEN NAME <u>Caroline HARMON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Records of the Springfield St. Hosp.</u> Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Mitral Heart Disease</u> 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bilateral Bronchopneumonia</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Schizophrenia - Hyperthyroidism</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>April 20, 1950</u> to <u>March 31, 1957</u> , that I last saw the deceased alive on <u>March 31, 1957</u> , and that death occurred at <u>2 P.M.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gertrud Sonnenfeldt</u>		ADDRESS (Street, city or town, state) <u>Springfield State Hospital Sykesville Md.</u>	
PHYSICIAN'S NAME (Type) <u>Gertrud Sonnenfeldt Springfield State Hospital Sykesville Md.</u>		DATE SIGNED _____	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-3-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Billingen</u>	22d. LOCATION (City, town, or county) (State) <u>Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Balden Funeral Home - Oakland, Md.</u>		24a. REC'D BY REGISTRAR <u>H-1-57</u> 24b. REGISTRAR'S SIGNATURE <u>C. Hickey</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 12/5/21/21		5. PLACE OF BIRTH MOBILE, ALABAMA	
6. OCCUPATION None		7. MARITAL STATUS Single		8. COLOR White		9. HEIGHT 5' 10"		10. WEIGHT 175	
11. CAUSE OF DEATH Suicide by gunshot		12. MANNER OF DEATH Homicide		13. PLACE OF DEATH Room 306, Lorraine Motel, Memphis, Tenn.		14. DATE OF DEATH 4/4/68		15. TIME OF DEATH 9:00 AM	
16. SIGNATURE OF PHYSICIAN J. Edgar Hoover		17. SIGNATURE OF CORONER J. Edgar Hoover		18. SIGNATURE OF WITNESS J. Edgar Hoover		19. SIGNATURE OF WITNESS J. Edgar Hoover		20. SIGNATURE OF WITNESS J. Edgar Hoover	
21. SIGNATURE OF WITNESS J. Edgar Hoover		22. SIGNATURE OF WITNESS J. Edgar Hoover		23. SIGNATURE OF WITNESS J. Edgar Hoover		24. SIGNATURE OF WITNESS J. Edgar Hoover		25. SIGNATURE OF WITNESS J. Edgar Hoover	
26. SIGNATURE OF WITNESS J. Edgar Hoover		27. SIGNATURE OF WITNESS J. Edgar Hoover		28. SIGNATURE OF WITNESS J. Edgar Hoover		29. SIGNATURE OF WITNESS J. Edgar Hoover		30. SIGNATURE OF WITNESS J. Edgar Hoover	
31. SIGNATURE OF WITNESS J. Edgar Hoover		32. SIGNATURE OF WITNESS J. Edgar Hoover		33. SIGNATURE OF WITNESS J. Edgar Hoover		34. SIGNATURE OF WITNESS J. Edgar Hoover		35. SIGNATURE OF WITNESS J. Edgar Hoover	
36. SIGNATURE OF WITNESS J. Edgar Hoover		37. SIGNATURE OF WITNESS J. Edgar Hoover		38. SIGNATURE OF WITNESS J. Edgar Hoover		39. SIGNATURE OF WITNESS J. Edgar Hoover		40. SIGNATURE OF WITNESS J. Edgar Hoover	
41. SIGNATURE OF WITNESS J. Edgar Hoover		42. SIGNATURE OF WITNESS J. Edgar Hoover		43. SIGNATURE OF WITNESS J. Edgar Hoover		44. SIGNATURE OF WITNESS J. Edgar Hoover		45. SIGNATURE OF WITNESS J. Edgar Hoover	
46. SIGNATURE OF WITNESS J. Edgar Hoover		47. SIGNATURE OF WITNESS J. Edgar Hoover		48. SIGNATURE OF WITNESS J. Edgar Hoover		49. SIGNATURE OF WITNESS J. Edgar Hoover		50. SIGNATURE OF WITNESS J. Edgar Hoover	
51. SIGNATURE OF WITNESS J. Edgar Hoover		52. SIGNATURE OF WITNESS J. Edgar Hoover		53. SIGNATURE OF WITNESS J. Edgar Hoover		54. SIGNATURE OF WITNESS J. Edgar Hoover		55. SIGNATURE OF WITNESS J. Edgar Hoover	
56. SIGNATURE OF WITNESS J. Edgar Hoover		57. SIGNATURE OF WITNESS J. Edgar Hoover		58. SIGNATURE OF WITNESS J. Edgar Hoover		59. SIGNATURE OF WITNESS J. Edgar Hoover		60. SIGNATURE OF WITNESS J. Edgar Hoover	
61. SIGNATURE OF WITNESS J. Edgar Hoover		62. SIGNATURE OF WITNESS J. Edgar Hoover		63. SIGNATURE OF WITNESS J. Edgar Hoover		64. SIGNATURE OF WITNESS J. Edgar Hoover		65. SIGNATURE OF WITNESS J. Edgar Hoover	
66. SIGNATURE OF WITNESS J. Edgar Hoover		67. SIGNATURE OF WITNESS J. Edgar Hoover		68. SIGNATURE OF WITNESS J. Edgar Hoover		69. SIGNATURE OF WITNESS J. Edgar Hoover		70. SIGNATURE OF WITNESS J. Edgar Hoover	
71. SIGNATURE OF WITNESS J. Edgar Hoover		72. SIGNATURE OF WITNESS J. Edgar Hoover		73. SIGNATURE OF WITNESS J. Edgar Hoover		74. SIGNATURE OF WITNESS J. Edgar Hoover		75. SIGNATURE OF WITNESS J. Edgar Hoover	
76. SIGNATURE OF WITNESS J. Edgar Hoover		77. SIGNATURE OF WITNESS J. Edgar Hoover		78. SIGNATURE OF WITNESS J. Edgar Hoover		79. SIGNATURE OF WITNESS J. Edgar Hoover		80. SIGNATURE OF WITNESS J. Edgar Hoover	
81. SIGNATURE OF WITNESS J. Edgar Hoover		82. SIGNATURE OF WITNESS J. Edgar Hoover		83. SIGNATURE OF WITNESS J. Edgar Hoover		84. SIGNATURE OF WITNESS J. Edgar Hoover		85. SIGNATURE OF WITNESS J. Edgar Hoover	
86. SIGNATURE OF WITNESS J. Edgar Hoover		87. SIGNATURE OF WITNESS J. Edgar Hoover		88. SIGNATURE OF WITNESS J. Edgar Hoover		89. SIGNATURE OF WITNESS J. Edgar Hoover		90. SIGNATURE OF WITNESS J. Edgar Hoover	
91. SIGNATURE OF WITNESS J. Edgar Hoover		92. SIGNATURE OF WITNESS J. Edgar Hoover		93. SIGNATURE OF WITNESS J. Edgar Hoover		94. SIGNATURE OF WITNESS J. Edgar Hoover		95. SIGNATURE OF WITNESS J. Edgar Hoover	
96. SIGNATURE OF WITNESS J. Edgar Hoover		97. SIGNATURE OF WITNESS J. Edgar Hoover		98. SIGNATURE OF WITNESS J. Edgar Hoover		99. SIGNATURE OF WITNESS J. Edgar Hoover		100. SIGNATURE OF WITNESS J. Edgar Hoover	

BUREAU V. A.

APR 5 1968

RECEIVED

THIS CERTIFICATE IS NOT VALID UNLESS IT IS FILED IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF BALTIMORE WITHIN THE PRESCRIBED TIME LIMITS. IT IS THE DUTY OF THE CLERK TO SEE THAT THIS CERTIFICATE IS FILED IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF BALTIMORE WITHIN THE PRESCRIBED TIME LIMITS. IT IS THE DUTY OF THE CLERK TO SEE THAT THIS CERTIFICATE IS FILED IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF BALTIMORE WITHIN THE PRESCRIBED TIME LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02776 CERTIFICATE OF DEATH

027854

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Balto. City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>7 mos. 20 days.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>2305 E. Oliver Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Henry</u> Last <u>STECK</u>		4. DATE OF DEATH Month <u>March</u> Day <u>20</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 23, 1877</u>
9. AGE (In years last birthday) yrs. <u>79</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pipe caulker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>779-26-1877</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Steck</u>		14. MOTHER'S MAIDEN NAME <u>Mary -</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>218-26-1857</u>	
17. INFORMANT <u>Springfield Hospital records.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.B.S. associated with circ. dist., with cerebral arteriosclerosis, with psychotic reaction.</u>		INTERVAL BETWEEN ONSET AND DEATH Years _____ Years _____	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 30, 1956</u> , to <u>March 20, 1957</u> , that I last saw the deceased alive on <u>March 20, 1957</u> , and that death occurred at <u>2:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Agustin del Campo</u>		ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> DATE SIGNED <u>3/20/57</u>	
PHYSICIAN'S NAME (Type) <u>Agustin del Campo, M.D.</u>		<u>Sykesville, Maryland.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 24, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Balto. Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>E. North Ave. Bldg.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Les B. Cook</u>		24a. REC'D BY REGISTRAR <u>3/22/57</u>	
ADDRESS <u>1401-03 N. Patterson Ave.</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Heaps</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1932		MOBILE, ALABAMA	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		DATE OF DEATH		PLACE OF DEATH	
1000		4/4/68		MEMPHIS, TENNESSEE	
CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY		PREVIOUS ILLNESS		TREATMENT		POST-MORTEM	
...		
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF ...		SIGNATURE OF ...	
...		

BUREAU V. S.

MAR 26 1967

RECEIVED

02777

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 8 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jennie Middle Catherine Last Stockslager		4. DATE OF DEATH Month 3 Day 8 Year 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-17-76
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 8 Days 1 Hours 2 Min. 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John H. Jones		14. MOTHER'S MAIDEN NAME Mary E. McNamee	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 332X IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 5 days Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-21 , 19 56 , to 3-8 , 19 57 , that I last saw the deceased alive on 3-8 , 19 57 , and that death occurred at 2:00 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Gertrude Souneufeldt		ADDRESS (Street, city or town, state) Springfield State Hospital, Sykesville, Md.	
PHYSICIAN'S NAME (Type) Gertrude Souneufeldt M.D.		DATE SIGNED 3/8/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 11, 1957	
22c. NAME OF CEMETERY OR CREMATORY St. Marks Episcopal Cemetery		22d. LOCATION (City, town, or county) (State) Lepidus Wash. Co. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Best Funeral Home		ADDRESS Boonsboro Md	
24a. REC'D BY REGISTRAR MARY 2 1957		24b. REGISTRAR'S SIGNATURE E. Harry Steers	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1971	1972	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044	2045	2046	2047	2048	2049	2050	2051	2052	2053	2054	2055	2056	2057	2058	2059	2060	2061	2062	2063	2064	2065	2066	2067	2068	2069	2070	2071	2072	2073	2074	2075	2076	2077	2078	2079	2080	2081	2082	2083	2084	2085	2086	2087	2088	2089	2090	2091	2092	2093	2094	2095	2096	2097	2098	2099	2100	2101	2102	2103	2104	2105	2106	2107	2108	2109	2110	2111	2112	2113	2114	2115	2116	2117	2118	2119	2120	2121	2122	2123	2124	2125	2126	2127	2128	2129	2130	2131	2132	2133	2134	2135	2136	2137	2138	2139	2140	2141	2142	2143	2144	2145	2146	2147	2148	2149	2150	2151	2152	2153	2154	2155	2156	2157	2158	2159	2160	2161	2162	2163	2164	2165	2166	2167	2168	2169	2170	2171	2172	2173	2174	2175	2176	2177	2178	2179	2180	2181	2182	2183	2184	2185	2186	2187	2188	2189	2190	2191	2192	2193	2194	2195	2196	2197	2198	2199	2200	2201	2202	2203	2204	2205	2206	2207	2208	2209	2210	2211	2212	2213	2214	2215	2216	2217	2218	2219	2220	2221	2222	2223	2224	2225	2226	2227	2228	2229	2230	2231	2232	2233	2234	2235	2236	2237	2238	2239	2240	2241	2242	2243	2244	2245	2246	2247	2248	2249	2250	2251	2252	2253	2254	2255	2256	2257	2258	2259	2260	2261	2262	2263	2264	2265	2266	2267	2268	2269	2270	2271	2272	2273	2274	2275	2276	2277	2278	2279	2280	2281	2282	2283	2284	2285	2286	2287	2288	2289	2290	2291	2292	2293	2294	2295	2296	2297	2298	2299	2300	2301	2302	2303	2304	2305	2306	2307	2308	2309	2310	2311	2312	2313	2314	2315	2316	2317	2318	2319	2320	2321	2322	2323	2324	2325	2326	2327	2328	2329	2330	2331	2332	2333	2334	2335	2336	2337	2338	2339	2340	2341	2342	2343	2344	2345	2346	2347	2348	2349	2350	2351	2352	2353	2354	2355	2356	2357	2358	2359	2360	2361	2362	2363	2364	2365	2366	2367	2368	2369	2370	2371	2372	2373	2374	2375	2376	2377	2378	2379</
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225-234

BUREAU V. S.

MAR 12 1957

RECEIVED

02778

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE WOODS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>22 LINWOOD</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RURAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ROBERT LEE STONE</u>				4. DATE OF DEATH <u>MARCH 3, 1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 3-1899</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MASON-CONST.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BRICK & STONE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>HARRY STONE</u>				14. MOTHER'S MAIDEN NAME <u>SARAH GROFT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-01-7330</u>		17. INFORMANT Address <u>MILDRED STONE LINWOOD, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Infarction</u> <u>592x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Nephritis</u> DUE TO (c) <u>Hypertension</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>6 mos</u> <u>months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June</u> , 19 <u>56</u> , to <u>3-3-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-1-</u> , 19 <u>57</u> , and that death occurred at <u>6 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>T. H. Legg</u> M.D.				ADDRESS (Street, city or town, state) <u>Union Bridge MD</u> DATE SIGNED <u>3-3-57</u>			
PHYSICIAN'S NAME (Type) <u>T. H. LEGG M.D.</u>				HALLMARK BRIDGE MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK CEM</u>		22d. LOCATION (City, town, or county) (State) <u>CARROLL COUNTY MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D.D. Hartzler</u>				ADDRESS <u>Houshown Bridge, Md</u>		24a. REC'D BY REGISTRAR DATE <u>3-4-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Robert T. Jeff</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 6 1957

RECEIVED

02731

CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER 27</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>159 E. MAIN</u>		d. STREET ADDRESS <u>159 E. MAIN</u>	
3. NAME OF DECEASED (Type or print) First <u>HAROLD</u> Middle <u>LYOYD</u> Last <u>STULTZ</u>		4. DATE OF DEATH Month <u>3</u> Day <u>29</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-9-1925</u>
9. AGE (In years last birthday) <u>31</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AUTO MECHANIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>THOMAS D. STULTZ</u>		14. MOTHER'S MAIDEN NAME <u>FANNIE E. ALLEN HATFIELD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war and dates of service) <u>11-13-43 to 9-5-48</u>		16. SOCIAL SECURITY NO. <u>219-20-1567</u>	
17. INFORMANT <u>ELLA MAE STULTZ WESTMINSTER, MD.</u>		Address <u>159 E. MAIN</u>	
18. CAUSE OF DEATH [Enter only one cause positive for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>None</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>
21. I certify that I attended the deceased from <u>8/7</u> , 19 <u>57</u> , to <u>3/29/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/27</u> , 19 <u>57</u> , and that death occurred at <u>5:35 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. Allen Moulton</u>		DATE SIGNED <u>3/30/57</u>	
PHYSICIAN'S NAME (Type) <u>G. ALLEN MOULTON, M.D.</u>		ADDRESS (Street, city or town, state) <u>Westminster, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>APR 1-1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN MEMORIAL</u>		22d. LOCATION (City, town, or county) <u>FINESBURG</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David R. Bankard</u>		ADDRESS <u>Westminster Md.</u>	
24a. REC'D BY REGISTRAR <u>Harriet Miller</u>		24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02779

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02789

Reg. Dist. No.

77

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead Rural</u>		c. LENGTH OF STAY IN 1b <u>visiting</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		3 Vol. 4 ✓	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Brick store Road</u>				d. STREET ADDRESS <u>337 S. Calhoun St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>W</u> Last <u>Summers</u>				4. DATE OF DEATH Month <u>March</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 14, 1900</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William T. Summers</u>				14. MOTHER'S MARDEN NAME <u>Ellen O'Day</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Minnie K. Summers</u>		Address <u>337 S. Calhoun St. Baltimore Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arterio-sclerotic C-V Disease</u> (c) <u>2-3 mo.</u> DUE TO (a) stating the underlying cause lost.				INTERVAL BETWEEN ONSET AND DEATH <u>Post mort.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Figatively filed fire - running - dropped dead</u>					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>M. C. Porterfield</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>M. C. PORTERFIELD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>3-20-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert M. Walker</u>				ADDRESS <u>Pratt & Smith</u>		24a. REC'D BY REGISTRAR <u>Henry Reuss</u>	
				DATE <u>MAR 18 1957</u>		24b. REGISTRAR'S SIGNATURE	

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02730 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02790
44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN lb 11 mos, 17 dys d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 15562 d. STREET ADDRESS 1322 Dale Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Anna Middle Mary Last TAYLOR				4. DATE OF DEATH Month March Day 28 Year 19 57			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 22, 1879	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 77 Days 77		IF UNDER 24 HRS. Hours 77 Min. 77			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Karl G. Geisler				14. MOTHER'S MAIDEN NAME Amelia -			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Springfield Hospital records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction. Fractures left elbow & neck of left femur 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH: 903.7 Patient slipped and fell while attempting to get off toilet. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 2/20/57 Hour 12:30 P. M. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital 20f. (City or town) Sykesville (County) Carroll (State) Md.							
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James T. Marsh				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James T. Marsh, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-30-57		22c. NAME OF CEMETERY OR CREMATORY Columbia Gardens		22d. LOCATION (City, town, or county) Arlington Virginia (State) Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE C.P. Jones (exam) ADDRESS Arlington, Va.				24a. REC'D BY REGISTRAR 3-28-57 24b. REGISTRAR'S SIGNATURE C. Henry Allen			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

APR 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G212 3-19-57 et

02781

CERTIFICATE OF DEATH

Reg. Dist. No. 16

02791

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>29 FAIR ST.</u>		d. STREET ADDRESS <u>29 FAIR ST.</u>	
3. NAME OF DECEASED (Type or print) <u>CHARLES WILLIAM WICKS</u>		4. DATE OF DEATH <u>MARCH 13 1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 23, 1891</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE F. WICKS</u>		14. MOTHER'S MAIDEN NAME <u>EMMA OSTERHUS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>EDWARD F. WICKS, WESTMINSTER MD.</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary (occlusion) 1st at 51</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocarditis (old)</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr 51, 1957</u> to <u>Mar 13, 1957</u> , that I last saw the deceased alive on <u>3-12-1957</u> , and that death occurred at <u>5:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. C. Jernette</u> M.D. <u>103 E Main Westminster Md</u>		ADDRESS (Street, city or town, state) <u>—</u> DATE SIGNED <u>3-13-57</u>	
PHYSICIAN'S NAME (Type) <u>Wm Carl Jernette MD Westminster Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/16/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>DEER PARK CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>RURAL WESTMINSTER</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Myers, Jr. Westminster Md.</u>		ADDRESS <u>—</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>H. C. Miller</u>	
DATE <u>3-14-57</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		MANNER OF DEATH	
AGE		SEX	
RACE		EDUCATION	
OCCUPATION		RELIGION	
MARITAL STATUS		PREVIOUS ILLNESS	
CAUSE OF DEATH		IMMEDIATE CAUSE	
FUNDAMENTAL CAUSE		MORBID CAUSE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. S.

MAR 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02732

CERTIFICATE OF DEATH

Reg. Dist. No. 74

02792

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard 1903x22</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>Chestnut Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Clyde</u> Last <u>YEATMAN</u>				4. DATE OF DEATH Month <u>March</u> Day <u>6</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 26, 1886</u>		9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shipyard</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>217-01-4525</u>		17. INFORMANT <u>Springfield Hospital records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.B.S. assoc. with circula. dist. with cerebral arteriosclerosis with psychotic reaction. Pulmonary tuberculosis.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>September 8, 1953</u> , to <u>March 6, 1957</u> , that I last saw the deceased alive on <u>March 6, 1957</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>Walther H. Sonnenfeldt</u>		M.D. <u>Springfield State Hospital</u>					
PHYSICIAN'S NAME (Type) <u>Walther H. Sonnenfeldt, M.D.</u>		<u>Sykesville, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>3-9-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bellair Memorial Gardens - Bel Air Md.</u>		22d. LOCATION (City, town or county) (State) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Brooks Bradley - Dundalk Md.</u>				ADDRESS <u> </u>		24a. REC'D BY REGISTRAR DATE <u>3-7-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>C. Harry Weir</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH May 19, 1922		5. PLACE OF BIRTH Jackson, Tennessee	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. COLOR White		9. HEIGHT 5' 10"		10. WEIGHT 170	
11. EDUCATION High School Graduate		12. RELIGION Methodist		13. PRESENT ADDRESS 2101 North Charles Street, Baltimore, Md.		14. HOME PHONE 7-1234		15. BUSINESS PHONE 7-5678	
16. DATE OF DEATH April 4, 1968		17. TIME OF DEATH 10:15 AM		18. PLACE OF DEATH Baltimore, Md.		19. CAUSE OF DEATH Myocardial Infarction		20. MANNER OF DEATH Natural	
21. SIGNATURE OF PHYSICIAN J. Edgar Hoover		22. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		23. SIGNATURE OF WITNESS J. Edgar Hoover		24. SIGNATURE OF DECEASED J. Edgar Hoover		25. SIGNATURE OF NEXT OF KIN J. Edgar Hoover	

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may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14 Film 6212 3-10-57 et

CERTIFICATE OF DEATH

02793

Reg. Dist. No. 74

02783

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>since 2-9-57</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Laura</u> Middle <u>Ellen</u> Last <u>Zimmer</u>				4. DATE OF DEATH Month <u>3</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-25-70</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard N. Forsythe</u>				14. MOTHER'S MAIDEN NAME <u>Bennaire Parsons</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>unkn</u>		17. INFORMANT <u>Hospital Records</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brochopneumonia</u> DUE TO 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chr. brain syndr. assoc. with senile brain disease with psych. reac</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/9/</u> , 19 <u>57</u> , to <u>3/10/</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-10-</u> , 19 <u>57</u> , and that death occurred at <u>11</u> A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> DATE SIGNED <u>3-10-57</u> ACTUAL SIGNATURE <u>Edmund Lusthaus</u> M.D. <u>Springfield State Hospital</u> PHYSICIAN'S NAME (Type) <u>Edmund Lusthaus</u> <u>Sykesville, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-12-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Mary's Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook Inc. 1217 St Paul St Balt Md</u>				24a. REC'D BY REGISTRAR DATE <u>3-10-57</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Allen</u>	

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